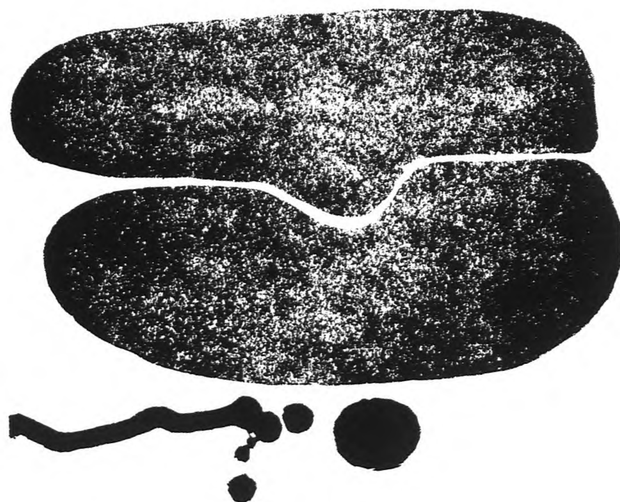
Journal
of the
Balint Society

2005



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Editor: John Salinsky
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A meeting of the Balint Society Council

The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is an annual residential weekend at Oxford and at Chester. Occasional weekends and study days are held elsewhere in the country.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

Programme of Meetings of the Balint Society for the Thirty-sixth Session, 2005-2006

Lecture series 2005-2006

All lectures are held at the Royal College of General Practitioners
14 Princes Gate, London SW1 1PU
Time: **8:30 p.m.** (with coffee from 8.00 p.m.)

Dr John Salinsky — Tuesday 25 October
'Franz Kafka and the night call from Hell'

Dr Sotiris Zalidis — Tuesday 6 December
'Tolstoy's psychosomatic imagination in Anna Karenina'

Dr Andrea Sabbadini, psychoanalyst and film enthusiast — Tuesday 21 February
'The talking cure from Freud to Almodóvar'

Dr Gillie Bolton, research fellow in medicine and the arts — Tuesday 21 March
'Through the looking glass: reflective writing and professional development'

Dr Michael Sheldon — April
Title and exact date to be announced

The Group Leaders Workshop meets every two months at the Tavistock Clinic, Belsize Lane. London NW3 at 8.30 pm.
The next meeting will be on Thursday 21 October 2005

The Chester Balint Weekend 2006 will be held in May.
The Oxford Balint Weekend 2006 will be held in September.
(Exact dates to be announced)

The **Annual Dinner** will be held on Tuesday 27 June 2006 at The Royal Society of Medicine.

Further information from the Hon. Sec. Dr. David Watt.

THE BALINT SOCIETY WEBSITE

The Balint Society has its own internet website. The address is *www.balint.co.uk.*

Unlike some addresses, this one is very easy to remember and to find.
When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader training.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress. There is now a NEW INTERNATIONAL BALINT FEDERATION WEBSITE at www.balintgesellschaft.de/ibf
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on www.balint.co.uk you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to www.balint.co.uk

Editorial

The Doctor, his Patient and the Illness – revisited

Michael Balint's book, *The Doctor, his Patient and the Illness,* was first published in 1957. This is the book that introduced Balint groups to the world. Everyone in family medicine has heard of it and we in the Balint movement speak of it with reverence and respect. We recommend it to our students and our registrars. But how long is it since we read it ourselves? If we read it again, we will approach it with a new curiosity. New questions will arise. How does Michael Balint's 1950s group compare with the ones we have today? What was he really trying to do, or in the language of narrative medicine, what story was he trying to tell?

In the introduction, Balint tells us straight away of his discovery that the most frequently prescribed 'drug' is the doctor in person. A lot of important things are going on psychologically between the GP and the patient that only the GP can observe. But the GP doesn't quite understand what is happening because he is not psychologically trained. In order to further the research, Michael had to train the doctors in psychotherapy and find a way to do this.

What did the 'training' consist of? This is not explicitly stated, but one of the first things he must have done was to encourage the doctors to get the patient back for a long interview. Once that begins, the floodgates are opened and the patients pour out their personal stories for the first time. Nowadays we rarely do long interviews and Balint himself changed his mind about them. In the later book *Six minutes for the patient,* he declared that the long interview was 'a foreign body' in the heart of general practice. Many GPs were relieved because they now felt free to apply the method to all their patients and not just selected ones. But in the 1950s, the long interview was essential. Balint also says that the doctors had to *learn how to listen*; in a way that would involve 'a limited but considerable change in personality'. How did this happen? It seems, from the text and from appendix 1 on Training, that this was largely taught by example. He listened attentively to the doctors as they presented their cases and they were given a model to use with their patients. There were no lessons in interviewing and communication skills. And definitely no videos.

The book contains 28 case histories that give us a historic picture of what life was like in north London in the early 1950s. One has the impression that the patients' lives are rather sad. Most people are very poor and there isn't a great deal to do. Rock and Roll has not been invented and Swinging London will not arrive till the 60s. The shadow of war still hangs over everyone. Some patients had been injured in the war or had become prisoners. There is a great fear of tuberculosis. Parents are strict and the young are sexually frustrated. The chief source of entertainment seems to be the cinema, which is mentioned surprisingly often.

What sort of illnesses did the patients present to their doctors? Balint observes that people who are unable to express their emotional distress will convert it into a series of physical symptoms, which they offer to the doctor. The doctor turns down the first few offers by saying: 'I can find nothing wrong with you. Don't worry'. But of course, this reassurance doesn't work and the patient tries again. Finally, the doctor accepts an offer, an illness is agreed and the two of them settle down to treat it over the next few years. Specialists are called in but they are all useless. Often a referral ends up with the famous 'collusion of anonymity' where the patient is passed from one specialist to another with nobody taking responsibility for the whole person.

When the doctor offers a long interview, there is spectacular change. The patient releases all the details of his or her unhappy life and begins to feel better. At last, there is someone who will listen! The doctor is excited but apprehensive. Suddenly he has turned into a psychotherapist. But what happens now? He is like a trainee pilot who has managed to get the plane off the ground but isn't at all sure how to fly it. Most worrying of all, he has no idea how he is going to land safely. The book has chapters called 'How to begin' and 'When to stop' to deal with these questions. Some of the doctors are only too eager to keep flying. Some report spending an hour a week with the patient, in one case on a Saturday afternoon! The more ambitious ones make bold interpretations, just like they imagine an analyst would. Balint seems unperturbed by their clumsiness. But he does warn them not to go too fast, not to interpret before the patient is ready and not to be too intrusive. There are some successes and some failures. 'Dr H', who seems to be the only woman in the group, does some of the best therapeutic work. She is not only bold and brave but sensitive, and is able to cope with a male patient who has sexual fantasies about her. It is a little ironic that a book called the 'Doctor *His* Patient and the Illness' should have a woman doctor giving an object lesson to the men.

But most of the doctors do not have ambitions to be therapists. Many are content with the gains that follow the first long interview. Some find further opportunities to listen and to help. Balint refers to what he calls 'the special psychological atmosphere of general practice'. By this he means the way in which the ongoing relationship allows the doctor to stop being a therapist when the patient has had enough, and to go back to being an ordinary doctor. He may later treat the same person for a cough or a painful back or even deliver her baby. But if the patient wants to talk about herself and her feelings again a few months or years later, the doctor is again

available to be a therapist. A psychiatrist can't do this. When it's over, it's over. Some GPs, instead of being therapists, rely on what Balint scathingly calls their 'Apostolic Function'. He explains that all of us have firm ideas about how people should live their lives and manage their illnesses and some of us are unable to resist trying to convert the patient to our point of view. Balint says this is like using 'common sense' and is therefore useless. However, he has to admit that sometimes it seems to work. One doctor tells a patient's husband that he must allow his wife to have a baby because it is her right as a woman. The husband accepts that he must change his attitude, the baby is born and the wife feels much better! Another doctor is able to convert some of his patients to his belief in the psychosomatic nature of their symptoms. Whatever the doctors do, Balint always has an open mind. He is willing to learn as well as to teach by example.

How does all this compare with the world of 'Balint' today? If the Michael Balint of the 1950s were to come back to pay us a visit, would he recognise the groups that carry his name? Would we accredit him as group leader or would we say: 'Sorry, Michael, you are going to need further training'?

The first difference that stands out is that we no longer try to turn GPs into psychotherapists. The long interview has all but vanished. But we still value good listening. In the book, we don't find the leader asking the doctors about their feelings. Nor to imagine how the patient might be feeling. The word 'empathy' does not occur. Balint does say in one place that it's important to be aware of the feelings that come from the patient but it does not seem to be a regular part of his technique. There is also no mention of the group having a supportive function for its members or helping to protect them from burnout. We attach great importance to this nowadays, and many old group members have confirmed that they did appreciate the support and believed that without the group, burnout would have overtaken them.

What would the group have been like? Could we have survived in it? I think you had to be pretty tough. Michael doesn't say anything about protecting the doctors from aggressive questioning or criticism. Perhaps Enid's influence was important in the development of the group process and the emotional climate of the group. Michael Courtenay who was in their group in the 1960s says that she would intervene 'to protect the chicks' if Michael was getting too abrasive.[1]

Should we still encourage our students to read *The Doctor, his Patient and the Illness?* I definitely think we should. They should read it firstly because it's a classic: a book that changed general practice forever. It has influenced not just people like us who are involved with Balint groups but everyone who works in primary care. It was the first book to study and describe the process of consultation. It was the first book about patient centred medicine. And it laid the foundations for what we are doing now. Balint work and Balint groups may have changed but some of the most important ideas are there in the book. They include learning to listen; being curious about the patient as a person with feelings and a life story; the difficulties of dealing with psychosomatic symptoms; not trying to go too quickly; and the need to be tenacious and to keep trying.

It is also fascinating to trace the development of Michael Balint's thought as the book progresses. Towards the end, in the two chapters on the 'The Apostolic Function', he seems to acknowledge that all doctors are different and that he is not going to produce a standard model of a GP psychotherapist. One can imagine him thinking: 'I've shown them how to listen but after that, they might as well be themselves. They will all do their own thing anyway and that's how they will get results.' Then in chapter XX ('General Practitioner Psychotherapy') he says that the doctor can take risks but he should never forget that he is a family doctor and not an amateur psychiatrist. He also stresses the importance of the Mutual Investment Company: the store of experiences that doctor and patient build up together over a period of time. We really need to be able to stay with our patients to do this kind of work. One can only hope that governments and health planners will recognise how vital it is for patients to have continuity of care from the same doctor over a period of many years if they are to receive the benefit of this kind of treatment.

JOHN SALINSKY

Reference:

1. Courtenay M and Salinsky J (2004) 'An Interview with Michael Courtenay' *Journal of the Balint Society* 32: 6-9

A Balint Study of Difficult Doctor-Patient Relationships that Cause Diagnostic and Management Dilemmas

Clive D. Brock MD, Alan H. Johnson PhD, Richelle J. Koopman MD, Alexander W. Chessman MD, Jonathan L. Sack MD

Abstract

Background:

We used patients presented in established Balint groups to clarify which kinds of doctor patient relationships are most difficult for family medicine residents.

Methods:

Consecutive cases representing difficult doctor patient relationships which were presented at the second and third year family medicine resident groups at the Medical University of South Carolina were searched for maximum variation. Each of these difficult relationships was thematically coded by the investigators who met face to face once a week to discuss the work of the groups. The investigators also participated in an ongoing iterative discussion regarding the types by email. A type was defined by consensus of the investigators. They continued until all cases presented fitted one of our types, i.e. they had reached saturation. These types were grouped into categories of those representing diagnostic or management dilemmas, or both.

Results:

Ten types were identified, with some difficult relationships representing multiple types. Most types reflect an unhelpful role for the doctor in the relationship or possible pitfalls for the doctor.

Conclusions:

In all the types we identified, the resident is stopped or diverted from being effective in his/her role as physician. Teaching residents about these common scenarios may help them avoid common pitfalls that can lead to frustration and/or serious medical errors.

Background

Caring for patients can be difficult and is made all the more problematic when the patients fall into the category of 'the difficult patient,' a patient who in the pre-computerised medical records era was called 'the thick chart patient'. These difficult patients have also been described as 'heartsinkers' and typically present emotional and social problems in physical terms (1). They include those patients with personality disorders who place greater demands on the medical system (2). A major cause of burnout or defensive responses (3) for the conscientious clinician can be repeat visits from difficult patients for a distressing problem with no apparent solution (4). Certainly those patients who pull the clinician into 'a web of complexity, ambiguity and family intrigue' create a drama that can significantly obstruct patient care (5).

Balint group training can help clinicians learn to deal more effectively with medical conditions in difficult patients. Balint group training is used in over two hundred family practice residencies (48%) in the United States (6,7). Balint groups discuss cases of troubling doctor patient relationships involving patients with ordinary medical conditions. The group applies a process, analogous to clinical reasoning, to illuminate the trouble in the doctor patient relationship. A basic assumption of the Balint group process is that once the patient is seen in a different light, the resident experiences a more genuine sense of understanding of the patient's illness. This empathic understanding leads to more effective medical care for what would otherwise remain a difficult patient.

The specific problems that residents encounter in caring for medical needs of difficult patients have not been carefully examined. Not all difficult doctor patient relationships have the same underlying difficulties; in fact these difficult relationships have several unique manifestations. How to work with difficult patients is a skill that we need to address with residents in their training (8). Examining the specific types of cases that cause diagnostic and therapeutic dilemmas for the resident will, therefore, help us address residents' learning needs and better prepare them for clinical practice. This study is a qualitative analysis of cases that family practice residents presented in a Balint group because they found caring for these patients' medical needs challenging. This information may help us train resident physicians to improve care and to avoid frustration, burnout and medical errors.

Methods

We examined written case summaries of consecutive cases presented over a fifteen-month period at the second- and third-year family practice resident Balint groups at the Trident Family Medicine Residency Program associated with the Medical University of South Carolina. These summaries were generated by the Balint leaders from notes and memory immediately after Balint groups. The summaries included elements of the group's processing of the case. These summaries were then sent to all authors via email. Patient and resident identities were kept anonymous. The authors felt that audio or video taping of groups would be too intrusive on the Balint process, especially for trainees. Investigators met face to face once a week to discuss their analysis of cases and participated in an ongoing iterative hermeneutic analysis of the cases and emerging themes via email.

Hermeneutics is an art and a philosophy of ongoing interpretation that invokes the imaginative, but publicly verifiable, re-enactment of the subjective experiences of others (9). Thus, we 'joined in' the doctor patient relationship under discussion. We disciplined ourselves to become subjectively involved in the doctor patient relationship and in the presentation of the patient. In other words, we consensually arrived at an empathic understanding of the doctor patient relationships; the typology emerged naturally from these understandings. Memos, in the form of emails, were kept to inform the ongoing process of type identification.

The cases were searched for maximum variation. Types were defined by consensus of the group. Each case was classified as a new type or as one that already existed. The names for the types were inspired by the cases presented, often a direct quote from the resident presenting the case. We continued to sample cases from November 2001 through January 2003, at which time all cases presented fitted one of our types, i.e. we had reached saturation. We then sent descriptions of these types to an international selection of Balint leaders, experts and researchers, for comment and review for the purposes of validating our results. As well, we sought feedback from the nurses at the clinic and several experienced clinicians. We also performed member checks with the residents themselves after our sampling was complete and the types were defined. We organised the identified types into a taxonomy of patient presentations that caused diagnostic difficulties, management difficulties, or a combination of the two.

The Institutional Review Board of the Medical University of South Carolina approved this research. Four of the authors are Balint leaders, credentialed by the American Balint Society. Of these, one is a counselling psychologist, and the other three are family physicians. The remaining author (RK) did not attend or lead a resident Balint group but is a Balint trained family physician with experience in qualitative methods. This author participated only in discussions of the cases, specifically to provide an external, yet informed view to aid in the generation of a typology.

Results

Ten types of patient were identified from the presented cases. The types were further organised into those that posed diagnostic dilemmas, those that posed management dilemmas, and those types that were associated with both diagnostic and management dilemmas. The six types which occurred most frequently are presented first with illustrative examples. Descriptions of the four less commonly occurring types follow, without illustrative cases.

Diagnostic Dilemmas

'The illusionist'

The illusionist, either through his actions alone, or in combination with 'the system', distracts the physician from the presenting problem. The physician focuses on a history of conflict with the patient, such as previous battles over narcotic pain medicines, and does not attend to today's presenting problem. This type of 'smoke and mirrors' behaviour may not be purposeful on the part of the patient, but it is his modus operandi. The resident attends to the distraction and is armed against it thereby, addressing it while missing potential blatant and serious pathology. In other cases, family members or other health care workers play the role of distracters as well, turning the resident away from an unbiased evaluation of his/her patient.

Illustrative case: The patient presents with a neck mass and hoarseness, but the nurse tips the doctor off that the patient is a 'drug-seeker'. The patient has a history of receiving prescriptions for narcotics. The doctor misses the blatant neck mass in his preoccupation to avoid mis-prescribing a narcotic during the visit.

'The stray dog'

In these cases, there is a loss of depth to the patient's personhood and humanity; the patient is stereotyped to be beyond medical treatment, a lost cause. The patient's destitution is public, but the pathos of the situation touches the doctor's sympathies, handicapping him in his ability to do his job. As with a lovable stray, the doctor throws the patient a scrap of attention and he goes away. The doctor's and patient's immediate needs for human attention are ameliorated. Both doctor and patient avoid a truly professional, responsible relationship.

Illustrative case: A 46-year-old drug-addicted double amputee enjoys seeing his doctor. He would unexpectedly pop in to see his doctor and be willing to wait as long as a whole day, if necessary, to be seen, 'just like a stray dog'. The doctor also enjoyed seeing the patient, and each encounter would start at a social level and would end with samples of Viagra being dispensed. The patient lost his legs in a single car accident while involved heavily in drugs and alcohol, which remains an ongoing problem. The doctor pitied him, and tolerated his ongoing problem with addictive substances. There did not seem to be time to address either the patient's hypertension or substance abuse problem. In follow-up, this patient's medical problems evolved into a stroke and a near vegetative state due to bacterial endocarditis

Management Dilemmas

'The caregiver'

The caregiver is that patient who poses a management dilemma because she seems to care for everyone else but herself. The patient consistently manifests poor adherence to the prescribed medication and lifestyle changes. It becomes clear to the provider that one of the barriers to medication adherence is the patient's overwhelming sense of responsibility to care for

others, typically her family or other people in need. The patient gives and gives and gives, but bears the full brunt of his/her own illness as if to underscore a sense of self-sacrifice. The consistent poor adherence, to the detriment of the patient's own health, is frustrating for the resident physician.

Illustrative case: A 30-year-old woman presents with diabetes and hypertension which are consistently poorly controlled. She is the mother of a child suffering from terminal non-inherited muscular dystrophy, to whose care she has devoted herself. The patient weighs over 300lbs and has a history of adoption at age 6 for abuse in a foster home. She is divorced from an abusive man and remarried. The resident struggles with helping the woman to care for herself effectively, and wonders why she keeps coming back with such poor control of her type 2 diabetes and hypertension.

'You're the one, doc'

The patient who tells the doctor that she is 'the one', 'the best doctor I ever had', 'not like those other doctors' may at first seem to be complimenting the doctor. However, in this situation, the doctor can be sculpted into a statue of an idealised physician and placed on a pedestal. Because the doctor is now stuck on the pedestal, the doctor's actions are limited. She can easily lose credibility and often must work diligently to sustain her exalted role as 'the one,' sometimes contrary to his/her best medical judgment. This type of physician-patient relationship may be difficult to negotiate for any physician, but is probably especially troublesome for the resident physician who might have difficulty setting aside the praise of a patient for her in her new role as a physician.

Illustrative case: A 50-year-old woman with a history of multiple injuries related to spousal abuse and chronic pain presents with requests for pain medications. The doctor and patient continue the chain of typical visits where the patient puts the doctor on a pedestal, telling everyone how good the doctor is; and finally gets what she wants, more pain medicine. The resident feels 'seduced' by this patient's praise and does not want to fall off the pedestal by denying the patient's request.

Both Diagnostic and Management Dilemmas

'Running out of labels'

This patient is inconsolable. The doctor investigates the patient's complaint but can never quite label or alleviate the problems. Reassurance is asked for by the patient and given by the physician; however, it does not reassure. The doctor and patient get caught up in an endless cycle of diagnostic tests without beginning to approach the patient's real problem.

Illustrative case: A female with chronic pelvic pain and a known history of childhood sexual abuse presents to her physician. She has had a hysterectomy, repair of an incisional hernia, vertigo, putative heart disease, and is currently undergoing psychotherapy. The patient still wants to know what's wrong with her. The pelvic pain persists with no response to invasive and non-invasive measures. The doctor feels at a loss about what to do next.

'The stranger'

The doctor gets a view into the patient's world, which appears strange to him. The patient's world can often appear dysfunctional, but closer examination can show it does function, albeit in an unconventional way. In order to be effective, the doctor must advocate from the patient's worldview, not from her own. Sensitivity to cultural, familial, and individual idiosyncrasy requires a shift from the usually fixed paradigm of the doctor's thinking. Even though our first impression may be 'how horrible', a second look often shows there is a functioning, loving family system. The resident's experience in his/her family unconsciously establishes the normative standard for relationships in the patient population. Balint work is required to extract those standards from the unconscious and apply them more discriminatively in practice.

Illustrative case: This is a case of a 16-year-old pregnant girl with an unplanned pregnancy who is going to keep the baby. At first, she wasn't making antenatal visits. Later, the patient always came with her mother, a woman in her early thirties. The mother seemingly treated her without fondness. What was surprising to the presenter was that the patient would go to bed at night with her mother and curl up against her and hold her close. It was hard for the doctor to reconcile the disparaging remarks in the office and the cuddling by night. The group realized that they were, in their own way, preparing for the new baby. In follow-up, appropriate generational boundaries and bonding were noted when grandmother, mom, and new baby were seen at a recent well-child check.

Less common types

'The ventriloquist' (Diagnostic and management dilemma)

The patient often presents dramatically through a child or symptom, frequently carrying a self-limited condition or non-specific complaint. The patient is readily consoled. The patient is presenting his/her distress through projection on the family and environment. This deflects the doctor away from the real patient. Unlike the 'illusionist', who is cast in a role by past history or medical staff that distract the doctor, the 'ventriloquist' creates distraction by projecting symptoms on others. It is as if the 'ventriloquist' uses the identified patient or symptom to speak for him or herself.

'Passing the hot potato' (Management dilemma)

Here, the partner or a family member carries the emotion for the identified patient. This emotion becomes infused with anger, which then focuses

on the doctor, allowing for some relief, as in passing a hot potato. By catching the hot potato, the doctor in a manner of speaking, has his hands too full to do his job.

'Quick sand' (Management dilemma)
Here a patient comes in with an urgent need for help. The patient's frantic concern tempts the doctor to 'jump right in', thereby becoming the doctor's frantic distress. The doctor puts great effort into helping but is judged to have fallen short. What looked like solid ground is revealed to be quick sand.

'Walking on egg shells' (Management dilemma)
Here, it is as if the patient were to say, 'There is no room in my life for the sick role, I'm fragile and I'll break. You can be very damaging if you don't tread softly'. The patient's self-concept and family and social roles cannot suffer a life altering diagnosis and its implications for management. This state is akin to the patient being pre-contemplative about the actuality of having an illness.

Multiple types
More than one type can occur in the same patient presentation, adding to the complexity of the visit and the potential distress of the resident physician. This vignette will illustrate the difficulty a resident experienced in containing a family systems issue that was fraught with anxiety. The reader will note the mixed types of 'Passing the hot potato', 'quick sand' and the 'caregiver' in the case.

Illustrative case: A resident presents a seven-year-old boy with ADHD who is brought in by his mother to refill a prescription for medication. On further investigation it emerges that the child has been experiencing florid visual hallucinations for the past few weeks. His mother was discharged from a psychiatric hospital the day before where she had spent several weeks for a failed suicide attempt. She is depressed and appears to be taking her son's story 'in her stride.' The resident learns that the mother is responsible for the care of her elderly bed ridden mother and her own husband who is disabled with a bipolar disorder. The doctor was upset and felt an urgent need to have the child admitted to a psychiatric hospital that same day but ran into the mother's vehement opposition. He was also unable to secure a visit for the child with a psychiatrist for another three weeks. This left him feeling angry and abandoned. The Group quickly identified the anxiety that the child and his family must be feeling around the mother's hospitalised absence. Much of the discussion reflected on how this family system might operate and how the child's behaviour might serve in redirecting the doctor's attention to caring for the mother. In other words, the identified patient might be attempting to coordinate the family's health care. The resident presenter was able to think more clearly about his management options for this family after his own sense of anxiety was 'contained' by the group. It is expected that the resident's own experience of containing anxiety within the group will be transmitted to containing the family's anxiety under these distressing circumstances.

Discussion
Each of these types of difficult patients that residents presented in Balint group represent a challenge to the physician, but they are all challenging in their own specific way. Some types may be more challenging for certain physicians than others. The resident physician may for example be distracted by an 'illusionist' so much that he fails to make the diagnosis. Analogous to a professional athlete, the physician needs to ignore the distraction and stay focused on her professional role. The resident physician needs to 'stay in the game' and focus on what he has been trained to do, or his performance will suffer and he will make uncharacteristic errors in diagnosis which may have medical and legal consequences.

Similarly, the physician may have difficulty with management due to obstructions in the relationship, but she must focus on good practice, assimilating but not reacting to distractions from the patient or the system. She may need to adopt a new paradigm for taking care of these patients. For example, the medical management conundrum that the 'caregiver' poses is how to care for a person whose very self-concept is dependent on looking after others at the expense of self. The usual case management approach must adapt to succeed with the 'caregiver'. The resident, as a new physician, may have particular difficulty throwing aside the accolades from a patient who proclaims 'you're the one, the best doctor I've ever had' and get down to the business of doctoring.

While we reached saturation at our site, one limitation may be that there may be unique issues that stop residents from being effective doctors at other sites. We checked the credibility of our results by having other credentialed Balint leaders throughout the United States and the world review our typology. Most felt the types were accurate, valid, and helpful, as did practising physicians and nurses. Furthermore, after the completion of this research, we presented the types to the residents themselves, who endorsed them so wholeheartedly that they have since used them in presentations at morning report and grand rounds for teaching purposes.

Conclusion
The identification of these ten types can bring both residents and attendings to an awareness of the professionally unhelpful roles into which they have fallen. With this awareness the appropriate question can then be raised, 'What kind of doctor do I need to be to effectively manage this patient's illness at this time?' These ten types may not be an exhaustive list. However, they illustrate the product of a clinical reasoning

process used in Balint-group work that helps move the physician out of his/her frustrated, deflected and dramatic role with the patient into a professional, effective role to deal with an immediate and finite problem in a more personal, humane way.

References

1. Butler C. C, Evans M. The 'heartsink' patient revisited. The Welsh Philosophy and General Practice discussion Group. Br J Gen Pract 1999; 49 (440): 230-233.
2. Hueston, W J, Werth J, Mainous A G. Personality disorder traits: prevalence and effects on health status in primary care patients. International J Psychiatry in Medicine 1999; 29: 63-74.
3. Salinsky JV, Sackin P. What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation. Radcliffe Medical Press, Abingdon UK. 2000.
4. Hardelin L. Balint group discussion as a prophylaxis for burn-out in physical medicine. J Balint Society 2002; 30: 5-10.
5. Miller, W L. Routine, Ceremony or Drama: An Exploratory Field Study of the Primary Care Clinical Encounter. J Fam Pract 1992; 34: 289-296.
6. Johnson AH, Brock CD, Hamadeh G, Stock R. The current status of Balint groups in US family practice residencies: a 10-year follow-up study. Fam Med 2001; 33(9): 672-7.
7. Addison, R B. A Grounded hermeneutic editing approach. In B. F. Crabtree & W. L. Miller (Eds.) Doing qualitative research. 2nd Ed. Thousand Oaks, CA: Sage Publications, 1999:145-161.
8. Borell-Carrio F, Epstein RM. Preventing errors in clinical practice: a call for self-awareness. Ann Fam Med 2004; 2(4): 310-316.
9. Audi R, Ed. The Cambridge Dictionary of Philosophy. New York: Cambridge University Press, 1995.

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Do we really have a choice?

A French response by Louis Velluet to last year's editorial 'How would you like your Balint?' from the French Balint Bulletin no. 55 Spring 2005 page 21 translated by Alison Harvey

No doubt John Salinsky's piece could seem to be a rather oversimplified quick run through the problem, but to treat it as such would be to risk failing to acknowledge the seriousness of the matter he invites us to consider. In my view it is to his credit that he has provided concrete illustrations of the ambiguities that tend, very regularly, to poison any discussion of Balintian practice (and I say firmly 'practice').

First, he mischievously contrasts the Oxford groups, led by generalists, with the Tavistock groups led by psychoanalysts or psychotherapists with an analytic training. The suggestion is that their ways of running groups could be different. However, if I consider all the francophone practice I have been able to observe, it does seem that the models he sketches for the conduct of these two sorts of groups, far from contrasting, are complementary. What actually matters is to know, and to apply, them all, but at different times, according to the particular dynamic of the group considered as a whole. The necessary circumspection where the personal lives of presenters and participants are concerned and the possibility of providing interpretations of the clinical material presented are not characteristic of one type of group over another.

The description, taken literally, seems thus to attach little importance to the specific characteristic of every truly Balintian training group: the extent of the analytic training of the group leaders.

This is a fundamental point. It is too often overlooked that what is of prime importance is the group leaders' capacity to perceive the outcrops from the unconscious movements of the presenter and those listening to him/her, and their ability to manage these movements according to the demands of a particular situation, a particular 'here and now'. For me the official social practice of these group leaders counts for less than their specific skills, and the knowledge acquired through their professional training, which has allowed them to develop those skills. I note in passing that the topic of the therapeutic relationship in the context of subjects' daily lives must never be neglected in professional training if we wish to remain faithful to Balint's thinking.

In the same way, our author distinguishes groups where displays of emotion are accepted, if not desired, from those where these are to a greater or lesser extent suppressed. The first are said to be found more frequently on the continent. There, once more, humour masks an essential idea that is rarely set out with clarity. It is of fundamental importance not to confuse superficial emotional reactions, too often sought by inexperienced group leaders, with reactions relating to the unconscious processes to be deciphered. To content oneself with the 'emotional touching up' that so irritated Lacan is not conducive to effecting, albeit limited, change in the participants. On the contrary, the latter are more often held back when the atmosphere in the group is maintained at a level of defensive hysterisation.

The real work is elsewhere. Essentially it consists in understanding what underlies the dynamics of a clinical situation in which the complex demands of a patient and the response given him/her by a healer vested with therapeutic responsibilities meet. The visible emotional reactions are the tip of the iceberg. To take into account these only confines us to the primary world of behaviour and obscures the real motivations underlying the conduct of the two protagonists.

One can usually judge the true level of the group leaders' training by the intensity of the fear they exhibit of entering into the sum of the personal questions posed by the presenter. This fear is most often illusory: work on the concrete elements of how the protagonists relate in the situation presented is, on the contrary, a protection against the excessive reactions feared. To remain on the surface looks less dangerous, but leads inevitably to recourse to formulae that can have the drawback of distorting the sense of the work. There is always the risk of sliding from psychodrama to banal role-play, if not to sterile, voyeuristic practice.

The desire to go quickly, without taking into account the fundamental processes that govern human beings, is a sickness of our contemporary medical pseudoscience. It would be a shame if, insidiously, it was to contaminate our practice. The smoke generated in formulaic groups soon clears and often leaves the participants as impoverished and disempowered as before. On the other hand, for work to be truly Balintian we must take care not to overload it with deceptive trimmings and accept the need to accord the time necessary for change.

Is it truly realistic to choose 'one's' Balint as one picks randomly from a menu? I think that it is preferable, having eliminated those shams that are the equivalent of the pasteboard chickens of our play meals as children, first to search for leaders who are unassuming but brilliant. People in whom we can have confidence; people whom we can value for the care and respect with which they approach living feeling beings. Then there is nothing to stop us, if we are still hungry, from going to join the other human feasts, participation in which is part of our remaining in a life that is authentic.

The introduction of Balint work into Sweden – the pioneer Lennart Kaij

By Kerstin Kaij, GP, Scania, Sweden, translated by Henry Jablonski

Translator's introduction:
By introducing Balint work into the Swedish medical culture and by being instrumental in having 'The Doctor, his Patient and the Illness' translated into Swedish, professor Lennart Kaij opened up new and previously unformulated perspectives to a generation of medical students and young doctors looking for alternatives. His initiative was very timely. It corresponded to the development of GP practice and to a deficiency, 'a basic fault', in medical training and practice that became very tangible in the 60s and 70s. The impact of Balint's book and Kaij's initiative on the attitudes to clinical work in Sweden within general practice and general psychiatry – the use of groups and teams for professional development and the dynamic outlook – can hardly be overestimated.

I had the privilege to meet with Kaij to discuss a research project – unfortunately only once due to his deteriorating medical condition. I spent an evening at his home in Lund. We were talking much more about general ethical and clinical matters than about my project. I found him intellectually sharp-minded and very warm. As a Swedish professor of psychiatry, I found him unique in his holistic and humanistic values. He was plain, sincere and committed on a clinical practical level. At the same time he represented the best of the Lundensian academic tradition.

The widow of Lennart Kaij, Kerstin worked as a GP for more than 30 years at Dalby, a suburb of Lund in southern Sweden (Scania/Skåne). Here she gives a short account of Kaij's contacts with Michael Balint and how his ideas came to Sweden.

Lennart Kaij, professor of psychiatry in Malmö/Lund 1969-1985, had an early understanding of the importance of the part of the general practitioner for well-functioning health care in our country. This view was not uncontroversial in a culture of medical sub-specialisation and organ/system fixation. Kaij maintained that the GP had a unique position to meet the demands of the patients in a holistic way by making both a medical and psychological assessment of the situation at an early stage of the 'career of illness' in a patient. He recognised that the GP had a difficult but exciting role in meeting with patients who presented an obscure clinical picture and thus were generally perceived as so called difficult patients.

In the mid-sixties Lennart Kaij got in touch with the ideas of Michael Balint through *The Doctor, his Patient and the Illness* through Niels Nielsen, the only practising psychoanalyst in southern Sweden in those days. The focus and methods expounded by Balint fit well into what Kaij had in mind. With the intention to learn more about Balint's method, Kaij established a contact with Balint and asked to join his seminars. He was welcomed, and for three months in 1967 Kaij came to take part in the meetings of the research group of Michael Balint. He became very impressed by Balint as a person. He perceived him as a charismatic, jovial but also as calmly, very attentive and a sharply observing person. He came to admire the ability of Michael Balint to make the members of the group talk about their observations and impressions in such a way that would make it possible for the group to formulate a fruitful hypothesis about the essence of the problems of the patient. Kaij was also very impressed by the individual GPs of the research group (who had provided the material for Balint's pioneering work in his book), by their knowledge, and by how generously and daringly they offered themselves as professional persons to the group work.

Enthusiasm and resistance

As Lennart Kaij came back home he was full of enthusiasm and energy. He saw to that *The Doctor, his Patient and the Illness* was translated into Swedish. He encouraged psychiatrists, psychologists and social workers at his clinic to become leaders of Balint groups. This endeavour turned out more difficult than Kaij had imagined. He was well aware that not all GPs would be interested in Balint's method. However those interested were fewer than he had imagined. In those days the total number of GPs was much less than today and the mental and cultural climate was fairly poor. For instance, an attempt to start a Balint group at the Dalby GP Centre was made in the beginning of the 70's with Lennart Kaij as its leader. It collapsed after a few meetings. Another attempt was made soon after with another leader. Nor did this attempt succeed in involving the group of GPs in Balint work. After some time the group was restarted under the leadership of the psychodynamically orientated psychiatrist Peter Silfverskiöld. He used a lot of patience and great skills as a pilot of the 'Dalby Balint Group ship' to navigate through shallow waters and reefs out to the open sea. To give a more general example of the rough climate for Balint groups in Skåne (Scania) in those days, I could mention the attitude of the professor of internal medicine, a person I have a profound respect for in many other ways. On one occasion he demanded to join a group meeting. Afterwards he declared that he would not accept what we were doing. This intervention made the group tighter and its members more committed, though.

Balint-inspired groups for medical students
At the psychiatric clinic of Malmö Lennart Kaij gave lectures on Michael Balint's method. They were highly appreciated. During the 'medical-surgical' year of training (the 6th and 7th semesters) when the students in those days met with patients for the first time in their training (sic!), they were offered participation in so called 'voluntary groups' which would meet regularly with a group leader for at least two semesters. Again, the professor of internal medicine threatened those students participating by declaring that they would meet with difficulties during their practice at the wards of his clinic.

The present situation in Skåne
Today the situation for Balint group work is different in Skåne. There are a lot more GPs and GPs in training than in the 70's. The base for Balint work is thus much broader. An increasing number of doctors realise that a Balint group can help to make the patients more interesting, the problems more understandable, and the doctor less frustrated. We do not know exactly how many on-going Balint groups there are at the moment but we know of quite a few. Still, in some places – particularly among senior GPs in executive administrative positions – we find a certain resistance and lack of understanding of the value of Balint group work for the doctor and his patients. In recent years we have tried to establish a Balint group leaders' training programme also in Skåne but the men and women in power did not think they had the economic resources for such a project. But we hope for the future!

Reflections on *A Fortunate Man*:

Text by John Berger, photographs by Jean Mohr. Reprinted by The Royal College of General Practitioners, 2003.

by Sotiris Zalidis

Nearly forty years since it was first published, John Berger has granted permission to The Royal College of General Practitioners to publish a limited edition of *A Fortunate Man*, his classic biographical essay of John Sassall, a country GP, who worked in the Forest of Dean in the mid 1960s. In this essay John Berger, an art critic, has used his vast erudition to articulate concepts that allow us to reflect on aspects of our relationship to our patients, to ourselves and to the society we live in, that make our work meaningful. His thoughts on recognition, common sense and the time scale of anguish are illuminating. The publication of this book is well timed because it affirms the central position of the emotional relationship between patient and doctor that is ignored by the avalanche of reforms issued by the government that are turning general practice into another impersonal job.

In this book he collaborated with photographer Jean Mohr who has contributed 74 photographs. John Berger in an interview has stressed that the photographs and his narrative should be seen as an integrated whole. Susan Sontag, in her book on photography, quoted Brecht who had pointed out that photographs alone could not explain anything. A photograph of the Krupp factory for instance reveals virtually nothing about that organization. In contrast to the amorous relation that is based on how something looks, understanding is based on how it functions. And functioning takes place in time and must be explained in time. Only that which narrates can make us understand.

The book starts with nine photographs of tranquil rural landscapes but the text warns us that the tranquillity is deceptive. The landscape is a screen, behind which the struggles, achievements and accidents of its inhabitants take place. The rest of the photographs are of people absorbed in various activities whose faces display emotions that are communicated directly to us, something that the narrative cannot do as effectively. The six case histories that follow give us an idea of the range of John Sassall's clinical activities.

1. He has to drive some distance from his surgery to respond to an emergency caused by an accident.
2. He visits a patient whose 32-year-old daughter suffers from intractable asthma that developed following a deep humiliation that she has never trusted the doctor sufficiently to divulge.
3. He visits a terminally ill woman whose family is in a state of deep sorrow about her imminent death.
4. In the consulting room he tries to offer practical advice to a young woman who despairs about her lack of education and chances of making something of her life.
5. He visits a woman in her late twenties who fears that she might have heart trouble because she has lost her sexual desire for her husband.
6. He visits a 73-year-old man at the request of his wife who is very concerned about his deteriorating health and cannot imagine living without him.

I first read the book 20 years ago when I was a GP trainee and found John Sassall's life and work inspirational. I too considered myself fortunate to be a general practitioner. When I heard however that John Sassall shot himself 15 years after the book was written I was shocked and wondered whether the word fortunate was misleading or overoptimistic. According to the Oxford dictionary the meaning of the word fortunate is: favoured by fortune, lucky, prosperous. How can somebody who is favoured by good fortune reach levels of despair profound enough to shoot himself?

When recently I reread the book carefully, I realized that John Berger uses the word fortunate in a very specific sense. He links it to the ideal of the universal man. The universal man strives to have many roles in his working life. It was the working ideal of Greek democracy and was revived in the Renaissance when it became a reality for a small number of men. John Sassall was fortunate in that he could elaborate his desire to be universal, to have many roles and to do what he wanted. In his practice he could do just about everything. He could perform operations, amputations, deliver babies, deal with emergencies, and in the evenings after supper he had long appointments lasting an hour with patients whom he believed he could help with psychotherapy. He was actively involved in the various activities of the whole community he was serving.

John Berger warns us that the enemy of the universal is the division of labour. At the beginning of the twenty-first century it is becoming increasingly difficult for contemporary general practitioners to achieve the ideal of the universal man that Sassall enjoyed in his working life. Division of labour has become a fact of our lives. Midwives deliver babies, casualty workers deal with accidents and emergencies, health visitors do vaccinations, community psychiatric nurses follow up the seriously mentally ill, counsellors and psychologists deal with the patient's distress, liaison nurses treat diabetics, practice nurses are increasingly involved in chronic disease management, we have given up our out of hours responsibility to nurse triage by

protocol, there are GPs with a special interest.

How did Sassall develop his appetite for experience and the desire to be a universal man? Unfortunately John Berger tells us very little about important relationships and events in Sassall's childhood that might have influenced his personal development. We learn that Sassall's father was a dentist and that he had the opportunity to meet doctors socially and hang around the dispensary of the local doctor and listen to consultations taking place in the next room. We learn that he admired physical prowess and being practical and using his hands. He was inquisitive about things rather than feelings. He was in revolt against his middle class family background but he had no interest in becoming a bohemian. Instead he was stirred like many boys of his generation by the ideal of a moral example which might shame the opportunism of his elders. We assume that as a boy he must have been interested in literature and must have read a lot because he allowed himself to be influenced by the books of Conrad. Against the boredom and complacency of middle class life ashore in England, Conrad offered the unimaginable whose instrument was the sea.

Indeed the metaphor of the sea and its unimaginable fury was central in Sassall's fantasy life. In the voyage of life, time is the sea, and emotions and illness are the stormy weather. As a boy he imagined that the doctor is the equivalent of a master mariner, the captain of a schooner, who in a crisis remains composed and in command when everybody else is fussing and agitated. He remains responsible for the many who depend on him: the passengers of the boat, the crew, the ship-owners, the brokers. John Berger tells us that it was from such material that Sassall constructed his ideal of responsibility. Perhaps it was Conrad's influence also that made Sassall start his medical career as a navy surgeon. During the war he was dealing with serious disease, and his surgical activities were saving lives in the Dodecanese, the Greek islands where he was based.

After the war he married and chose to practice under the NHS in a remote area. There he had plenty of opportunity to go on working as a life saver. He felt proud to be overworked and imagined himself as a mobile one man hospital. He performed appendix and hernia operations on kitchen tables; he had no patience with anything except emergencies and serious disease. The pace of his life made it impossible and unnecessary to examine his own motives and feelings. He was dealing with the unimaginable like the master mariners that Conrad described. They would deny it all expression and would project it all on to the sea which then they faced as though it were simultaneously their personal justification and personal enemy. He was using disease and medical emergencies as they used the sea.

However living among the same people all the time he began to notice how people developed. He became aware of his patients changing. They made confessions for which there was no medical reference as far as he had learnt. A man who had never been ill shot his brains out. A couple of old age pensioners who lived as husband and wife turned out both to be men. In his mid thirties he went through an identity crisis. He realized that a doctor in his position could not continue behaving like a master mariner. He could not go on projecting the unimaginable on to the diseases he had to treat. He realized that imagination had to be explored and be lived with at every level: his own imagination first – because otherwise this could distort his observation – and then the imagination of his patients.

He could have used some professional help at this point in his life, but the prevalent professional ethos and his isolation militated against seeking outside help or therapy. He attempted his own self analysis and started reading Freud. For six months, as a result of his resurrected memories, he became sexually impotent.

He emerged from the crisis having exchanged the life and death emergency for the intimation that the patient should be treated as a total personality, that illness is frequently a form of self-expression rather than the surrender to natural hazards. This was dangerous ground, for it was easy to get lost among countless intangibles and to forget or neglect all the precise skills and information which have brought medicine to the point where there is time and opportunity to pursue such intimations.

Although he stayed well informed by reading the three main medical journals, his satisfaction came mostly from those cases where he faced forces which no previous explanation would exactly fit because they depended upon the history of patient's particular personality. Sassall's new approach made the villagers feel recognized and this was probably what they valued most. John Berger is aware that he uses the word recognition to cover whole complicated techniques of psychotherapy and refers to Michael Balint's book The Doctor, his Patient and the Illness for a more complete discussion of the topic.

In summary however, he uses the term recognition to describe the essential function of the doctor that involves both diagnosis of physical disease and recognition of the patient's emotional state. This dual function is only possible in an intimate relationship that resonates with experiences of childhood. We submit to the doctor's exploration of our bodies and our mind by imagining him as an honorary member of our family. In illness we ideally imagine him as an elder brother or sister. What is required of him is that he should recognize us with the certainty of an ideal brother. When we become ill we fear that our illness is unique and that as an undefined force is a threat to our very being. To have our complaint diagnosed, recognized, defined and therefore limited and depersonalized is to be made stronger. It is a great relief when doctors

give patients a name for their disease. From then on it acquires an existence independent from them and they can now struggle against it and complain about it.

Most unhappiness is like a disease in that it too can exacerbate a sense of uniqueness. The person fails to find any confirmation of him or her self in the outside world, and this lack of confirmation leads to a sense of futility. This sense of futility is the essence of loneliness. Sassall tried to keep the person company in his loneliness. He recognized the man. If the man can begin to feel recognized – and such recognition may well include aspects of his character which he may not have recognized himself – the hopeless nature of his unhappiness will have changed. This emotional recognition can be achieved by the doctor presenting himself to the patient as a comparable man. It demands from the doctor a true imaginative effort and precise self knowledge. Over a certain period of time it is the doctor's acceptance of what the patient tells him and the accuracy of his appreciation, as he suggests how different parts of his life fit together, that will persuade the patient that he and the doctor and other men are comparable, because whatever he says of himself, or his fears, or his fantasies, seems to be at least as familiar to the doctor as to him.

Sassall related not only to individual patients but to the local community as a whole. The area he was working in was economically depressed. There were only a few large farms and no large-scale industries. Fewer than half the men worked on land. Most earned their living in small workshops, quarries, a wood processing factory, a jam factory, a brickworks. They formed neither a proletariat nor a traditional rural community. They belonged to the forest and in the surrounding districts were invariably known as the foresters.

John Berger explains that the culturally deprived have far fewer ways of recognizing themselves. A great deal of their experience – especially emotional and introspective experience – has to remain unnamed for them. Their chief means of self expression is consequently through action. This is why do-it-yourself hobbies are so important. The garden or the workbench becomes the only means of satisfactory introspection. John Sassall knew this, and so he had the idea of turning a wide moat, surrounding a medieval castle that was used as a damp, into a garden for the village. The job offered the possibility of talking together with the villagers and finally the talk transcended the job.

The foresters were proud that Sassall belonged to their community and recognized that he was privileged. The privilege did not concern his income or car, or home, but rather his way of thinking that was different from theirs. They depended on common sense and he did not. He confessed to fear without fear, he found all impulses natural or understandable, he remembered what it was like to be a child, he had no respect for any title as such, he could enter into other people's dreams or nightmares, he could lose his temper and then talk about the true reasons as opposed to the excuse for why he did so, he accepted his innermost feelings and intuitions as clues. His own self was often the most promising starting point. His aim was to find what might have been hidden in others. He did more than treat them when they were ill. He was also the objective witness of their lives, a function that John Berger describes as 'clerk of their records'. He kept the records so that from time to time they could consult them themselves. The most frequent opening to a conversation with him, if it were not a professional consultation, were the words: 'do you remember when…'

John Berger believes that Sassall had achieved his ideal of becoming a universal man as much as anybody could on land, dealing with illness and not the sea and living in the middle of the twentieth century. He had achieved a position comparable to that of a captain of a schooner.

He was trusted, he had access to 95% of his hospitalized patients, he dealt with all emergencies ranging from those that arise from serious accidents to suicidal despair, or the slow suffering and eventual collapse of a retired vicar who has lost his faith. His attitude to the individual patient was based on answering an unmade demand for recognition. To some extent he thought and spoke what the community felt and incoherently showed. To some extent he was the growing force of their self – self consciousness. But because the area he worked in was backward and depressed, it was subject to the minimum of direct influence from the outside, and therefore very few ideas came to challenge Sassall's hegemony. And yet the price for his achievement was the experience of acute stress.

The stress was the result of his isolation, his sense of responsibility and the way he worked. As a result of the special position that he had achieved and of the way he practised, he had to face far more nakedly than many doctors the suffering of his patients and the frequent inadequacy of his ability to help them. He did not believe in maintaining his imaginative distance. He felt he must come close enough to recognize his patients fully and he identified with them. Identifying with his patients was in keeping with his striving for the universal, his desire to have many roles, to become each and every patient and learn as much as possible about each person. Because he never separated an illness from the total personality of his patient, and because he identified with each patient, he felt compelled to share, at least in imagination, their elemental anguish six times a week. He considered it his duty to try to treat at least certain forms of unhappiness. He very seldom sent patients to mental hospital for he considered it a kind of abandonment. Whereas physical anguish can be relieved in a matter of minutes, anguish caused by dying, loss, fear, loneliness, being desperately beside oneself, a sense of futility, is more difficult

to relieve. It cannot be settled by writing a prescription.

Sassall's character would lead him to transform his pain into a sense of painful responsibility. When a patient died he blamed himself for what he had done or what he had left undone. Sassall was the slave of suffering, but he needed to work in this way because by curing others he cured himself. What made it more acute for Sassall was his awareness of a bitter paradox that provoked his disquiet. He could never forget the contrast between himself and his patients. Sassall expected the maximum from his life and his aim was the universal man. His patients expected very little. However he had to admit that what needed to be done was outside his brief as a doctor and beyond his power as an individual. Yet he had then to face the fact that he needed the situation as it was: that to some extent he chose it.

It was by virtue of the community's backwardness that he was able to practice as he did. Sassall could strive towards the universal because his patients were underprivileged! He was fortunate to the extent they were unfortunate! Their backwardness enabled him to follow his cases through all their stages. It granted him the power of his hegemony, encouraged him to become the consciousness of the district, allowed him unusually promising conditions for achieving a fraternal relationship to his patients, permitted him to establish almost entirely on his own terms the local image of his profession.

It is no wonder that from to time Sassall became depressed. The depressions might last two or three weeks, and although John Berger does not provide the information necessary to understand the origins of Sassall's depressions, he believed that they were maintained by the suffering of his patients and his own sense of inadequacy. Sassall was more sensitive to his patients' interests than the patients themselves, and his heightened awareness provided the justification for being depressed. He crushed himself in the contradiction between his developed sensibility and the underprivileged life of his chosen patients. John Berger concludes that despite his suffering, he was nevertheless a man doing what he wanted and therefore, like an artist or like anybody else who believes that his work justifies his life, Sassall by our society's miserable standards was a fortunate man.

Like Berger, who found it difficult to end his essay because Sassall was still alive at the time of writing and therefore his life and work had not been concluded, I also find it difficult to end this review but for the opposite reason. I find myself feeling concerned about the amount of stress that Sassall experienced and the fact that he tried to cure himself through work. I wonder whether his suicide after his retirement was partly the result of suddenly being deprived of the work that was his cure. I wonder whether his life might have ended differently if he had had some personal treatment, if he were less isolated, if he were able to discuss his cases in a Balint group. I wonder whether John Berger is reflecting on the origins of burn-out when he says that 'one of the fundamental reasons why so many doctors become cynical and disillusioned is that when the abstract idealism of saving lives has worn thin, they are uncertain of the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman: it is because they live in and accept a society which is incapable of knowing what a human life is worth. Finally man's worth to himself is expressed by his treatment of himself.'

I wonder whether Sassall, had he taken care of himself with the same compassion and tenderness that he had lavished on his patients, might, like John Berger, still be alive today.

References

Berger, J and Mohr, J. A Fortunate Man. RCGP 2003.

Sontag, S. On Photography. Penguin books 1984.

On attending Michael Balint's Medical Student Group in 1961-62

by Sonya Baksi, retired Consultant Community Paediatrician

Has medical education changed?

In early October this year, the BMJ carried an editorial on the process of creating a doctor. It referred to the hidden curriculum: the creation of the professional ritualised identity, emotional neutralisation, the loss of idealism, change in ethical integrity and acceptance of hierarchy. Is it really true that the teaching remains haphazard, and that bullying and humiliation remain commonplace?

Turning back to 1958 when I myself entered medical school, these negative accusations certainly applied. I had joined my teaching hospital when the NHS was only ten years old. Our training derived from the traditions experienced by those who trained us: our learning was formal, ordered and regularly tested. Disease was systematised and for the under 65s we had to make symptoms fit a recognised pattern and diagnosis. The over 65s, naturally, had multiple pathologies which challenged systemic analysis. I never remember any medical teacher discussing the fact that we had an NHS or debating its structure or significance. The sense of pride and professional identity, evident amongst our consultants, derived from belonging to a well-respected London teaching hospital with its established tradition and flourishing private wing.

That tradition included a formality in dress and manners. One of my pals received a note in his pigeonhole to the effect that young men who sport beards do not advance in the department. Students were indeed relegated to the lowest position in the pecking order. It was not uncommon for our teachers to mock or humiliate us. I remember being stood on a box to hold the retractor over a long period whilst my surgeon worked away deep in the abdomen. I could not see a thing, my arm began to ache and I was really scared to loosen the tension of my hold. I had been selected for this task because, the surgeon declared, I had marched from Aldermaston to Ban the Bomb, so I must have the strength for this job. (I wondered how he knew.) But it was the regular dissimulation of information from patients behind a screen of Latin that elevated the doctor's position. Today's aim of partnership with patients or patient help-lines was worlds away from the ethos of my training. Hospitals seemed to be run for the consultants with Ward Sisters ensuring that everything was in exact order before the ceremonial ward round.

We medical students progressed from 'firm' to 'firm' to witness the work of the various specialities. Unusual cases were demonstrated at the 'circus' sessions where we indeed sat in tiered rows rising above the floor-space where the training doctor would display the key features of his exposed, interesting patient. We would interpose our questions about the condition. We were encouraged to attend post-mortems, especially those of deceased patients whom we ourselves had 'clerked'. That was a really testing experience for us novices and we worked hard at showing the professional detached interest. General surgery and general medicine were the major draws. Public Health had such a low profile that only some half dozen of us attended the lectures. When we turned up at the Venereal Diseases clinic, we were asked why we had come as it was nearly all over thanks to penicillin. We were told that we should go to the pictures instead...which, being cinema addicts, we duly did!

An aberrant form of training!

Then, inserted into this pattern of training, we were given the option to attend the sessions run by Dr Michael Balint. A group of us friends used to do the weekly walk of a mile over to his place near Marylebone High Street. I guess this group included the 'misfits' of our study year. He asked us in turn to present a patient whom we were currently looking after. His angle was not so much to talk about the medical condition as the actual person. He would begin to ask querulous questions. We often were uncertain as we had not explored that aspect of the patient's life. His enquiries would become more penetrating and he would smile almost playfully at us as we searched for appropriate responses. He was breaking through the mould of fitting symptoms to systemic analysis and showing us how to think about why that patient had contracted that illness at that particular time. We were encouraged to think about how the illness affected the patient's personality, life, work situation, and nearest relatives. This approach humanised our consideration of the impact of disease. We found those weekly seminars highly stimulating. Of that group of friends, only one went on to a mainstream speciality. Several became adult/child psychiatrists, one became active in international family planning, two of us went into community child health and one in her mature years found her niche in doing sterling work for the Medical Foundation for the Care of Victims of Torture.

So what was the impact of those sessions on my career? Having chosen community child health, concepts of family dynamics and interactions affecting health and disease became the key substance of my work. At our Balint sessions, I recall provocative questioning about the evolution of the patient's sexual awareness, maturity and active sex life. This, in the early sixties, was before the reform of abortion law or availability of contraception on the NHS. There

was a veil of silence about sexual activity when we were students, although our teachers might well make suggestive remarks. I recall our gynaecologist asking me, personally, in front of the whole class, what my chances were of getting cervical cancer! Being ignorant of the link to many changes of sexual partner, I dourly replied: oh pretty high I should think!

The dramas of my early medical career were around supporting mothers in the face of insensitive male obstetricians, the completion of illegal abortions, caring for girls 'in trouble' in mother and baby homes who automatically parted with their babies after breast feeding them for the first six weeks, teaching mothers with no experience of contraception how to use the Dutch cap.

But society was changing. For all the provocative questioning in the Balint group, when in the late sixties, one of my teenage patients talked to me of her half siblings and step siblings, I did not know the technical difference. Over the years of my working life, attitudes to sexuality and patterns of parenting have dramatically changed. I have had to learn to work at understanding the effects of serial parenting, contact or not with absent parents, child sexual abuse, same sex parenting, open adoption, inter-country adoption and so many other situations which were never discussed or alluded to in those early sixties seminars. However, despite the dramatic changes in the societal and personal context, the key approach remains the same. We use what we understand to be the common human experience in reaching maturity and maintaining a healthy happy life to assess our patients' needs. Although exploring common key elements, our work holds a continuous fascination because of the infinite variability between the lives of the many individuals who seek our help.

Footnote

Debating whether medical students do receive a more sensitising training today, it was commented that with 300 in a year group, instead of our 80 students, it was difficult for the 'misfits' to find each other! Turning to GP practice, it was commented that with *NICE guidelines* on screen as each patient is seen, the doctor becomes obliged to devote more eye gaze to the computer and less to seek the unspoken communications of the patient!

Part of this lecture is an extract from the book *Yes, Health Minister: forty years inside the NHS working with children* by Sonya Leff to be published by The Book Guild Publishers Ltd in March 2006.

The 16th Michael Balint Memorial Lecture: 'One in a Million'

by Dr Paul Sackin, GP and Course Organiser past president of The Balint Society

given on 19 April 2005 at the Royal College of General Practitioners

When starting to prepare this talk I thought of Mussorgsky's *Night on the Bare Mountain.* Perhaps the experience of the hero of the opera *Sorochinsky Fair,* from which it comes, is not unlike that of the tyro GP (or, indeed, of many of us more experienced ones). Our hero falls asleep and dreams of the Witches' Sabbath on the eponymous mountain. The frightening vision of witches cavorting here and there in frightening array (all those horrendous patients all at once) somehow recedes and he is left with the vision of his lover and his determination to win her (perhaps patients are not that bad after all).

Anyway, so much for fantasy – for now, anyway. I really thought about this piece because we performed it in University College (UC) Opera in 1964. The producer's enthusiasm for Stanislavsky slowly became tamed when faced with the raw recruits of the University College Opera Chorus. His thrilling ideas for *Night on the Bare Mountain,* which we rehearsed for weekend after weekend, were just not going to work and we ended up singing the piece in more or less serried ranks of witches, wrapped in dark blankets to give SOME credence to our transformation (I was a peddler rather than a witch for the rest of the opera). This production was so exciting that I became a devotee of UC Opera and took part in their Haydn production in 1966. I was involved in rehearsals for the next opera, Donizetti's *Poliuto,* to be performed in March 1967, when it was announced that seminars led by Michael Balint would be available to us new clinical students from January 1967. Attendance at these seminars was much encouraged by Dr Tredgold and his colleagues in the psychiatry department. Having already decided that I was probably more interested in people than diseases, I was keen to give the Balint seminars a try. But, as luck would have it, the seminars clashed with rehearsals for *Poliuto.* With a maturity that I certainly lack now, I decided that *Poliuto* was a one-off – I would never again have the chance of singing in an opera chorus doing undiscovered music – whereas Balint would be available for much of my clinical course and missing a few weeks of it would not matter too much. It's quite possible that this decision changed my whole career. The early Balint seminars (that I missed) had about twenty participants and many of my colleagues were not impressed – the group seemed too big to work properly and there were few opportunities to present cases. Had I joined at the start perhaps I too would have been put off by the whole experience. In the event, by the time I did join, the group had settled at about twelve enthusiastic members and I was 'hooked'.

So, this was the beginning of my involvement with Balint work. Balint was actually only one of several important role models for me in my subsequent career as a GP and GP educator. It's about GP education that I want to talk tonight. Given that Balint training, as Michael Balint envisaged it, hardly exists in this country any more, is there any discernible Balint influence in the work others and I do as course organisers? If not, does it matter, and should anything be done about it? I'm going to be self-indulgent and describe some aspects of the educational work and research in which I've been involved. My theme is that all this has evolved from my interest in – indeed passion for – Balint work. But it is not by any stretch of the imagination 'pure' Balint even if it is patient-centred. Indeed, perhaps it is only one part in a million Balint, hence the title of my talk as suggested by John Salinsky, whose many talents include that of prize title deviser. But if homeopathy is anything to go on, one part in a million is quite effective enough.

But this is a Memorial Lecture, one that I am greatly honoured to be asked to deliver. So, let me continue with some memories of Michael Balint. I'm in one of my very first seminars. 'Who has a case', asks Balint. Well, I've sat quietly for long enough. Do I risk it? I don't really know much about this patient but he (that is, the patient – oh, and Balint himself) seem harmless enough. I find myself saying – I do. Yes, I admit I was the student who presented the case described on page 141 of *What are you feeling doctor.'*[1] It's a man of about 50 who has had a myocardial infarction. He seems to have made a good recovery but, being 1967, he needs a good ten days' rest on the ward. I see him every day for a little chat. Then one day he asks me when he can resume sexual intercourse. Covered in embarrassment I say that I don't know but will try and find out. I also feel a twinge of anger that he landed me with this question rather than the very nice registrar (OK, the house officer was a woman). I don't suppose the Balint seminar will be able to help, but nothing venture, nothing gain. Well, the seminar *did* help. For one thing, Balint asked if any of the students had had any teaching on this and if anybody knew any answers. None was forthcoming, so Balint suggested we go to the library and report back our findings next time. Yes, Balint was into all types of evidence-based medicine! As I remember it the literature was – and probably still is – inconclusive. What also happened in the seminar was that I found myself

saying quite a lot about this patient that I had no idea I knew. And I was left with some ideas about why the issue of resuming intercourse might be particularly important to this man. He was about fifty but had a son of only ten. He had no other children. He travelled abroad a lot. It wasn't difficult to speculate that his wife might not be his only sexual partner and that his 'past' might have been much more colourful than met the eye. My curiosity, both about the patient and about the scientific issues raised, had been roused. What greater motivation is there for good general practice and for continued learning?

Not long after I joined the student group, Balint received an invitation to lecture in Aberdeen on his work with medical students. He replied to them that a lecture would not convey what went on in the groups and the only way to do that would be a demonstration. Much to everybody's surprise, the Aberdonians agreed to this and two student groups (there were senior and junior groups at that time) went to Aberdeen for the weekend. I don't think I said a word in any of the group sessions. We were tastefully accommodated in the ECT ward of the local mental hospital and Balint kept a lovely avuncular eye on us all, plying us with whisky on the overnight train back. I think Balint often felt like the metaphoric prophet – not without honour except in his own country. He could get quite paranoid about the lack of support for his methods in UCH. Perhaps few, if any, consultants there were signed up members of a Balint group, but several were skilled in patient-centred medicine. A consultant on my first firm, David Edwards, was chiefly a physiologist researching into the sphincters of the gastrointestinal tract. He did occasional outpatient clinics, one of which remains in my memory after almost 40 years. He gave two patients about an hour each after which all the ramifications of their illnesses on their lives were infinitely clarified, I'm sure to their eternal benefit. The third patient got ten minutes and when we asked Edwards why, he said that he felt that the patient was so entrenched it was unlikely he could benefit from greater exploration and understanding. Perhaps this was arrogant but there is little doubt that it was also right (remember the chapter in *The doctor, his patient and the illness* – 'When to stop').[2]

Even more impressive was the paediatrician, Simon Yudkin. Fourteen of us were attached to his firm at UCH in February and March 1968. We were not known as angels but all 14 of us sat in rapt silence through all his outpatient clinics – nothing would get in the way of our attendance. Mini dramas of family dynamics were enacted in front of us, families showing such trust in Yudkin's interest and skill that they were not in the least put off by all us students. I still remember Debbie, a two-year old with enlarged neck glands. Yudkin simultaneously formed a relationship with her, explored her mother's ideas, took a traditional medical history, decided that a Mantoux test would be necessary, organised it by communicating non-verbally with the nurse, did the test and gave Debbie a cuddle afterwards. Was Yudkin just an exceptional doctor or did he have some premonition that he only had another month to live? So, for me, Balint was one of several inspirational figures. I felt that the clinicians were able to put into practice the sort of approach that Balint espoused in his seminars. If I kept going to these, perhaps I could become another Edwards or Yudkin.

What did Balint himself think about the seminars for students, a concept he initially opposed? Heather Suckling recently discovered a paper Balint wrote about these seminars along with his psychiatrist colleagues Dorothea Ball and Mary Hare (the latter faithfully transcribing all the seminars I attended and standing in for Balint on the very rare occasions when he was absent). The paper is entitled 'Training medical students in patient-centred medicine' and it was published in 1969 in an American Journal called 'Comprehensive Psychiatry'.[3] Balint suggests that there are three main differences between traditional medicine and patient-centred medicine:

1. Illness-orientated medicine is based on an uninvolved objective observer, while patient-centred medicine needs a participating or an involved observer
2. Illness-orientated medicine thinks in terms of pathologically altered parts of the body while patient-centred medicine thinks 'in terms of personality problems, conflicts and disturbed human relationships, as well as of physical illness'.
3. Illness-orientated medicine permits the doctor to gather information not obtained by him personally and to use it for therapy without the patient's knowledge or participation. In patient-centred medicine, the only information which can be used must be known equally to the patient and his doctor.

I think our august College would approve of this analysis! Balint went on to say that, 'some of the problems we wanted to study with the students were:

1. Could this approach lead to better understanding of the illness?
2. What kind of help could a student be expected to give to his patient when he adopted this approach?
3. What demands could we make on the student and he on himself?
4. What kind of training could be offered to the student to help his patients in this different way?'

After discussing the seminars and giving some vignettes, Balint concludes that question 1

can be answered in the affirmative, 'The patient-centred approach allows the student to discern an intelligible pattern in the patient's life history and behind his physical complaints and helps him to a more reliable understanding of the patient and his illness'. He is less certain about the answers to the other questions, arguing that the all-pervasive illness-orientated approach in the hospital makes it difficult for the students to change. 'If the importance of the emotional aspects of illness could be accepted, the student could be recognised as a useful ally for therapeutic work. In this way, more help could be given to patients who would welcome it and whose problems are otherwise ignored or, if recognised, are referred to our already overcrowded Department of Psychological Medicine'. (A totally exceptional department, I should add, then and I believe still now. In my experience psychiatrists are often more illness-orientated than many a physician and they certainly have the most rigid and non-patient friendly referral systems).

Balint's claims for the success of the student seminars are modest. He proposed that, in order to expand the learning opportunities, there would need to be compulsory seminars for six months in the first year and then students would be selected who are suitable for more advanced work. Clearly this has not happened. On the other hand there is arguably a wider acceptance of a patient-centred approach and students are exposed to patients very early in their training and encouraged and helped to understand them as people and family members. Believe it or not, even Cambridge has been dragged kicking and screaming into this approach.

Following vocational training based mainly at UCH and Kentish Town Health Centre, I became a partner in Waltham Abbey, Essex. During most of my time there, I went to a Balint group at UCH, led by Cyril Gill and Bernard Barnett. However, after a couple of years I felt that my career was not progressing in Waltham Abbey and I decided to look for a practice where I could be more involved with training. By great good fortune, I saw Bob Berrington's advertisement for a replacement second partner. Bob had just been appointed course organiser to the Peterborough scheme and therefore could not be paid to take on the trainee he had just appointed. Ideally, therefore, he was looking for a partner who was also eligible to be a trainer and I got the job. Unfortunately I had been a principal for three months less than the stipulated three years necessary before one could become a trainer. The visiting regional adviser (Ian Tait) asked me the dreaded question – why are you so special that you should be appointed before you have done three years? How does one answer this? Telling him that, yes, I am very special might be seen as somewhat immodest. On the other hand, saying that I'm not at all special, just perfectly ordinary and it's all a mistake, would not get me very far. Suddenly I knew what to say – through the luck of being in the right place at the right time rather than any brilliance on my part, I happen to have experienced seminars run by Michael Balint, and therefore I do have something rather unusual to offer. Unfortunately Ian Tait easily returned what I thought was a certain ace, 'Have you thought of running Balint seminars on the day release course?'

Once I had recovered my composure I had to admit that this seemed rather a good idea – though a daunting one. It eventually led to me becoming course organiser in 1981, a position I have held on and off ever since. It was rapidly apparent that I was no Michael Balint. Case discussion groups on the day release course seemed to generate into somewhat dysfunctional chats. The trainees were keen to raise all sorts of seemingly peripheral issues – or sometimes they didn't want to raise anything at all. I had to admit that I felt much more comfortable running MRCGP preparation sessions than I did case discussions. Something had to be done! Marshall Marinker had been one of several inspirational guest facilitators on the day release course that I attended at the Royal College of General Practitioners when I was a trainee at Kentish Town. (The course remains as a role model for my work as course organiser). By the time I was a struggling case discussion leader in Peterborough, Marshall was professor 'down the road' in Leicester. I therefore arranged to sit in on some of his case discussion sessions. I'll come back a bit later to say something of the methods he used.

Having sat in with one 'expert', I was beginning to think how interesting and useful it would be to learn from others. Once again I was fortunate to be in the right place at the right time. Some Schering scholarships for trainers were announced. Marshall helped me to submit a proposal and I was successful. The result was a three-month sabbatical that I spent travelling in England and Wales, visiting case discussion groups on 34 day-release courses. I'm almost embarrassed to talk about the methods used in this project compared with the complex methodology devised by Ruth Pinder and Anne McKee in the Society's much more recent research and which I will discuss later. Indeed, arguably there was very little 'methodology' as such. I simply visited the groups, made extensive notes, and tried to make sense of what I observed and what value it might have had for the trainees. What really struck me at the time was that I had quite a strong emotional reaction to many of the groups and I tried to use this to analyse their strengths and weaknesses. I like to think that this approach had some parallels with Balint's ideas – using one's emotional reaction to the patient to help understand the doctor-patient relationship. On a bad day, though, I feel my approach was completely anecdotal, subjective and invalid.

I ended up with dividing the case discussions into four categories[4] – those using cases to illustrate topics, those that were broadly supportive, discussions based mainly on problem

solving and those based on Balint's ideas. Those in the first two categories often irritated me because they were superficial and didn't give the trainees an opportunity to explore and understand what was really going on in their work. An extreme example was at one of the topic-based sessions when the theme of the day was 'suicide'. One trainee reported on a patient who had committed suicide the day after he had seen him. He was reassured that this could not have been prevented and his experience was used to help construct a list of approaches to potentially suicidal patients. While the group may have learnt something from this, the plight of this trainee was almost entirely ignored and the reassurance he was given was arguably, as Balint has pointed out, tantamount to contempt. His story was evidently too painful to dwell on or to learn from.

Most of the discussions I witnessed fell into the 'supportive' category. Many of these sessions resembled a GP surgery – a quick run through of a lot of cases, with a few interesting points emphasised by the course organiser and reassurance to the presenting doctor that he or she hadn't made any great errors. A few of these 'supportive' discussions made an attempt to encourage some examination of the evidence for statements made and even to challenge some of the contributions. A few used this much more challenging approach as the basis of the discussion, often only discussing one or two cases in an hour. Not long before I carried out my project, Marshall Marinker had written a book chapter about case discussions[5] and this was very much the approach he used in the seminars I observed in Leicester. Marinker argued that 'perhaps the most important gain from case discussions is the habit of critical thinking. So often definitive answers will elude the group. Elsewhere in this book much has been made of the virtue of tolerating uncertainty. It is a virtue born of necessity, but critical thinking in case discussion demands of the members of the group that they place limits on this uncertainty.' He adds later that, 'the good case discussion must achieve a balance between concern for the quality of the evidence, and a concern for the doctors' creative use of imagination, insight and intuition'

In the Leicester seminars the presenter was stopped at various points in the narrative and group members asked to consider what they felt and what they might do next. Although there are of course huge differences between Balint groups and this type of discussion, there are some similarities, particularly the idea of group members engaging in creative speculation rather than criticising or reassuring the presenter. I was very impressed with the few courses I observed using this approach. The trainees really seemed to be learning how to reflect on their work and to do things better next time. One of the groups that seemed particularly successful was St Thomas's in London and they subsequently described their course in some detail.[6,7,8] What is particularly fascinating about their work is that they found that basing their half-day release course purely on cases and situations brought by the participants, they covered a more relevant range of topics than in any published syllabus at the time.

The final category of case discussions was Balint style groups. When I did my research I had been rather out of touch with Balint work for a few years. I was therefore very struck with the power of these groups to help the trainees to try and understand what was really going on with their patients and in their relationships with them. One example was in the group run by John Carey on the Wycombe scheme (It may not be north of Watford but at least it wasn't London). This got off to an extremely inauspicious start, as it was a very foggy December morning and everyone (including me) was late. It would have been very easy to have a quick discussion of a few cases in the limited time now available. A trainee briefly described a patient who had had a myocardial infarct and her involvement after his discharge from hospital. She seemed anxious but her colleagues reassured her that she had done nothing wrong. Many a 'supportive' group discussion would have ended there. Instead John Carey pointed out that the presenting trainee was still looking anxious and the group would do well to explore that. In the 40 minutes available all facets of this case were explored, not least parallels between the presenter's father and the patient who happened to be the same age and parallels between the patient – who seemed to be a passive bystander within his family – and the trainee who had been treated a bit like a 'puppet' by her practice, doing all the work while those in power pulled the strings. No wonder one trainee at another Balint type group told me that 'we don't really look forward to the discussions but we really appreciate them when they've happened'.

Looking again after many years at the book, *Teaching General Practice*[5] in order to remind myself of the principles of case discussion espoused by Marshall Marinker, I was reminded of how opposed he was to the idea of Balint groups for students and trainees, arguing that Balint groups were concerned with 'an often painful exploration of the doctor-patient relationship over many years'. Only the continuing relationship between the doctor and the patient and between the group leader and members of the group made it possible to overcome the almost inevitable difficult periods in the group that the work entailed. This was obviously not possible in short-term groups. This argument was no doubt similar to that put forward by Michael Balint before he accepted the idea of the student group.

I had been invited to talk to the Balint Society about my project on case discussions. Partly as a result of that I became more involved with the Society and eventually became a Council member. One of the projects I took on was to convene a small group to look at the characteristics of Balint groups. As I recall it,

there were three main reasons for carrying out this work:

- To articulate the values that had been handed down from Balint that we felt were still important
- To encourage the formation of new groups and offer guidance as to how they might be run. We wanted to try and take out the mystique that surrounded Balint groups so far as some people were concerned
- To try and help those who were running different types of group to call them something other than Balint groups

We divided the key characteristics into 'essential' and 'desirable' and published the results of our deliberations in the 1994 Balint Society Journal.[9] One of my tasks was to write to Enid Balint to ask for her views and she was quite forthright in her reply. She did, however, suggest further discussion but sadly this was not to be as she died shortly afterwards. One of her key points of disagreement was the emphasis in our document on having skilled group leadership. She felt that we had overemphasised that at the expense of the psychoanalytic input. 'The original idea was to see whether psychoanalysts with their particular way of looking at their work and the problems of their patients could be of help to general practitioners who work in such a different setting but have patients who start by complaining with quite different symptoms and problems but are still patients showing the same kind of thing as shown to a psychoanalyst with his patient. Would the psychoanalyst be of any help? Would he enlarge the views and horizons of the general practitioner or not? And would the general practitioner perhaps enlarge the horizons of the psychoanalyst?' Enid also said that, 'I doubt very much whether he (Michael Balint) would have been pleased with the changes that have occurred. If he had had the time as I have to see the good that has come out of some of the changes he could have changed his mind but before he died he was very insistent that I should see to it that the kind of changes that have occurred should not occur!'

My main theme today is whether Balint groups have been 'diluted' as they have evolved and, if so, what it means and how much does it matter. I suspect Enid's point was that the 'modern' groups were not so much diluted as different – not training-cum-research seminars with psychoanalytical input as they originally were, but case discussion groups with only very limited psychoanalytical input, and that probably from a GP. I'll come back to these points as I try and summarise at the end. Now I would like to continue with my autobiographical approach to the subject.

At around this time, *The Doctor, the Patient and the Group*[10] had just been published and the Balint Society was thinking about another research project. A group of us got together under the leadership of Michael Courtenay and Erica Jones to work as a research group. Our initial project, suggested by Marie Campkin, was 'accidents'. This led to some fascinating cases being discussed but somehow it did not seem to lead to the development of principles that would have usefully added to the research literature. Michael Courtenay eventually proposed that we instead study doctors' defences. This idea had been in the back of his mind for many years – indeed since Tom Main's Balint Memorial Lecture of 1978. Tom Main had ended his lecture with a challenge: 'Perhaps your seminars could make room for deliberate experiments in the fashioning and use of elastic, bespoke medical defences tailored for each case and each doctor'. Given that we need defences in order to survive working with patients, could we bring these into consciousness and adjust them appropriately? This really meant exploring the 'doctor' end of the doctor-patient relationship much more than was normally the case in Balint groups, at least in this country. Michael Courtenay even had a vision that, if our work were to be successful, it would help to illuminate any professional relationship. For ordinary group members like me, while the discussions were fascinating and extremely useful for my work with patients, it was not always easy to see how we could develop coherent themes for our research. Well, I needn't have worried. Michael's vision kept the research alive and eventually led to the book, *What are you feeling, doctor?*[1] This was not quite a bestseller but it did succeed in putting the Balint tradition back at the heart of literature on the GP consultation.

I might have been content to rest on my laurels at this point, gloating over some of the good reviews we got for the book. But my colleagues in the Balint Society were keen to move on. If Balint work was to stay alive, continued research was needed. Perhaps now was time for the crunch. Do Balint groups actually 'work'? Do people learn from them in a way that is useful for their work with patients? Our group decided to look at groups for GP registrars, given that there aren't that many other Balint groups in the UK. We realised the difficulties of measuring outcomes – we didn't expect to be able to show that those attending Balint groups consulted in a more psychologically aware manner than their colleagues who didn't. Nevertheless we thought we could at least explore how Balint groups compared with other VTS groups in terms of their impact on doctors' interpersonal skills and understanding of the doctor-patient relationship. In one of the many preliminary discussions we had with various people, the late Paul Freeling was extremely helpful in taking these ideas further. Given that Balint groups may be a dying species in the UK, might we not look at whether there were any essential skills and insights gained in Balint groups that could not be acquired elsewhere? If the answer were yes, then there would be important evidence for continuing and

developing the Balint approach in vocational training. If the answer were no, it was likely that Balint's ideas had sufficiently permeated other groups and we need not be too worried at the possible demise of 'true' Balint groups in vocational training.

We planned a relatively simple pilot project to start to explore these issues. We would send a questionnaire to London course organisers to try and identify what sort of groups the various schemes ran, we would visit a few with Balint groups and a few with other case discussion groups to check out that they did what they said they did. Then we would invite a qualitative researcher to observe a few of each type of group, and interview some of the participants to explore the attitudes of the participants and their learning. Simple really! But we didn't bargain for Ruth Pinder, the researcher we eventually appointed, or Anne McKee, who supervised the project. They are both from an ethnographic background. They argued that if you are studying a 'culture', you study the culture, not compare it with another one. And you go for depth. So, they proposed to study only one VTS course running Balint groups. They agreed that looking at another course with different case discussion groups would be useful as a 'satellite' – another 'lens' with which to help understand the Balint group.

One of the most interesting features of this project was the dialogue between the researchers and we Balint-orientated GPs. As Ruth put it, 'Our work was about rubbing different conceptual blocks together –and sometimes the sparks flew'! We had spent a long time thinking about including an 'outsider' in our defences research and eventually decided against it. They might bring lots of expertise but it was hard to see how they could be incorporated into the Balint group that was the basis for that research. But in this project we found 'our' approach being explored and criticised by 'outsiders'. We probably were defensive of our territory but for me the main tension was because of the nature of the ethnographic approach. I much admired Ruth for her ability to find interest in, and draw conclusions from, virtually any encounter. But at the back of my mind remained a question of validity. Although as a result of this project I have come to understand quite a bit more about ethnography, at the time I wondered if it was really OK just to observe one Balint group on a few occasions and write a huge report as a result. This begs the question as to whether it *was* a Balint group. It may have been typical of Balint groups for GP registrars – though we can't be sure of that – but it certainly wasn't an ongoing group with input from a psychoanalyst. Be that as it may, given that it is likely that there are several groups running that are not unlike the one observed, the conclusions of the research and the further questions that it raises, are fascinating.

Ruth has written a detailed report from which I just want to mention one or two points that are in keeping with my theme of 'dilute' Balint. We were all gratified to read towards the end of the report that, 'rather than being 'diluted', as the GPs in the research team feared, there was every indication that Balint work was being re-invigorated to fit the demands of contemporary general practice. The research suggests that every Balint group is inevitably an interpretation, necessarily filtered through the lens of contemporary thinking and policy developments. There are arguably strengths and weaknesses of such groups. 'The stories told, and the imaginative group facilitation of those stories, opened new ways of thinking about the doctor-patient relationship'. On the other hand: 'An exclusive focus on the doctor-patient relationship could obscure other issues that troubled junior doctors. This focus, held through facilitation, is one example of how subtle forms of direction prescribed what could be said. Amid the openness was a process that implied what appropriate professional attitudes were and that shaped what could be discussed'. Ruth argued that 'judgements were paused' in the groups, 'not eradicated'. 'Part of the hidden curriculum was to learn what could be said and what could not'. Although people were sincere in their disclosures, they were also 'strategic', being careful before they spoke that what they said would fit with the group culture. And there is a lot of discussion in the report about group culture – the way the group ran and whether 'more examination and reflection on group processes' might have clarified and negotiated just what was meant by openness, for instance.

There is also much debate about the cultural mix of the group participants and their patients. Are there universal truths in the Balint approach or is it largely rooted in 'Eurocentric' traditions, when for many doctors and patients in the UK these days Eastern cultures and values predominate? I was reminded recently, hearing a fascinating talk by Glyn Elwyn, that there is a considerable amount of literature, going back virtually to Balint's time, using an anthropological model of the consultation. Elwyn's theme was the 'postmodern' consultation, where many other influences come into play as well as the cultural and the doctor-patient relationship. While some, such as the patient's family or the doctor's social network, would have been present in Balint's time, influences such as the Internet, patient support groups, government or the media, would have been less predominant or absent. One of the course organisers who ran the Balint group being studied in this research argued that, 'If I disturb them [the participants], I've done my job'. The same would seem to go for this research project. Ruth's findings certainly disturbed me and I suspect will disturb you when you read about them in detail. That must be a sign of good research!

In planning this talk I have become increasingly aware that my main role in all the projects I have mentioned has been that of editor

– drawing other people's ideas together and not necessarily majoring on too many original ideas myself. I think this characteristic of mine has been a key factor in the pragmatic way I have led case discussion groups as a course organiser. The prospect of giving this lecture has made me aware of the various emphases I have tried to give to case discussion groups with registrars over the years. In the autumn term of 2004 we seemed to reach a depth that hadn't happened for a while. I found it important to make a record of our discussion, initially so that I would remember what had gone on when it came to discuss follow ups and also for the benefit of those who had missed the session. I soon came to realise that doing a brief summary of the discussion and reflecting on it, might be useful for everybody. It hopefully might encourage the registrars to think further about the cases discussed and on the process of the group. It allowed me to offer some ideas for the registrars to consider at leisure, rather than interrupting the flow of the case discussion.

Reflecting on this talk, I'm not sure if my enthusiasm for Balint work comes over. Groups, say at the Oxford weekends, always seem to allow participants greatly to increase their understanding of their patients and often of themselves. There may be a certain amount of angst but this is countered by the support of the group. It is also almost always the case that the most junior medical student can make as useful a contribution as the most senior GP. I leave it to you to decide whether this 'feel good' factor about the groups is of any relevance at all in arguing for their worth

Finally, I've drawn together a few conclusions from my reflections:

- Balint was a key figure, perhaps *the* key figure, in the evolution of general practice and GP training
- Although his groups were 'research-cum-training'[2] seminars they were also models on which future case discussion groups were based
- Many of us, and not just in this Society, believe that Balint seminars still offer participants a unique experience, invaluable in gaining insight into their work with patients
- The patient-centred approach Balint espoused has become central to GP training though the language is different
- Contemporary Balint groups in the UK are mainly to be found in GP training schemes. The study of the doctor-patient relationship in these groups is illuminating to the participants in lots of ways but perhaps limiting in others. It could be argued that the groups exclude many areas that are of key importance in contemporary general practice
- Arguably a Balint approach deals with some of the 'needs' of GP registrars. A more pragmatic approach may engage them more and could also deal with their wider needs. However there is a danger that it might cater for 'wants' rather than 'needs' and be too superficial and 'reassuring'.
- Balint was arguably 'one in a million'. Does the Balint Society want to acknowledge this by continuing to work solely within the paradigm of the traditional Balint group – thus risking becoming antiquated – or by moving out into the general field of patient-centred approaches, thus risking losing its identity?

References

1. Salinsky J and Sackin P (2000) *What are you feeling, doctor? Identifying and avoiding defensive patterns in the consultation.* Radcliffe Medical Press: Oxford.
2. Balint M (1957) *The doctor, his patient and the illness.* London: Pitman. Millenium Edition, 2000. Churchill Livingstone: Edinburgh.
3. Balint M, Ball DH and Hare ML (1969) Training medical students in patient-centred medicine. *Comprehensive Psychiatry*, **10**, 249-258.
4. Sackin PA (1986) Value of case discussion groups in vocational training. *British Medical Journal*, **293**, 1543-1544.
5. Cormack J, Marinker M and Morrell D (1981) *Teaching General Practice.* Kluwer Medical: Brentford.
6. Savage R and Savage S (1994) From curriculum to self-directed learning with vocational trainees: (1) Facilitating a half-day release course. *Education for General Practice*, **5**, 14-18.
7. Savage R and Savage S (1994) From curriculum to self-directed learning with vocational trainees: (2) Can trainees generate their own curriculum? A prospective study. *Education for General Practice*, **5**, 120-127.
8. Savage R and Savage S (1994) From curriculum to self-directed learning with vocational trainees: (3) South East Thames region course organisers' assessment of trainee generated content of a half-day release course. *Education for General Practice*, **5**, 128-134.
9. Balint Society Council (1994) What is a Balint group? *Journal of the Balint Society*, **22**, 36-37.
10. Balint E, Courtenay M, Elder A, Hull S and Julian P (1993) *The doctor, the patient and the group: Balint revisited.* Routledge: London.
11. Main T (1978) Some medical defences against involvement with patients (Michael Balint memorial lecture (1978) *Journal of the Balint Society*, **7**, 3-11.

Reflections on The 16th Michael Balint Memorial Lecture: 'One in a Million'

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David Watt of the Balint Society extended a warm invitation to the 16th Michael Balint Memorial Lecture entitled *One in a Million*, held at the Royal College of GPs in London. Alan Wood and I attended.

The audience was made up of individuals of long association with the life and work of Dr Michael and his wife Enid Balint. It included GPs considering re-joining Balint training seminars to support their current clinical work in general practice, friends of the Society and ourselves representing the Association of Psychosexual Nursing. The lecture was given by past Balint Society President, Dr Paul Sackin, who currently practices as a GP in Cambridgeshire. Dr Sackin mirrored the history of the audience with his own. Amusing illustrations described the way that he fell into experiencing Balint-style case discussion seminars, and how years later he recognised that these were the foundational inspiration for his continued work on GP trainee schemes. For today's practitioners, Dr Sackin also described his current involvement in researching the relevance of Balint's work relating to the study of the doctor/patient relationship. Are so called Balint groups keeping to the basic tenets of his work? How much do some of the 'Case Discussion Groups' for GP trainees retain elements of the focus of the original Balint seminars? One part to a million (an effective dose in homeopathic terms)?

Dr Sackin and the research team were advised by their ethnographic researcher that the gathering of data had to be narrowed down to the study of one particular group. Dr Sackin mentioned two findings observed by the researcher within the group:

1) There appeared to be an unspoken group culture, that allowed some things to be said, but others not. This seemed to be absorbed through group attendance from the group leader.
2) That in the in-depth study of the practitioner/patient relationship, other wider issues of potential concern to the practitioner could be left out or ignored.

No particular examples from the study were given to illustrate these points. Some of the audience reacted to the first point as a potentially negative finding, and to the second as a possible problem.

These views might equate to some of the observations of Jan Savage's research into an Advanced Balint seminar for psychosexual awareness, *Emotions in practice. A study of Balint seminar training as experiential learning for qualified nurses (RCN Institute 2003)* that can at first, appear negative. Both to an observer and to the participants themselves, the work, for those who have not previously experienced the seminar training, may seem bewildering and painfully focused on the practitioner-patient relationship. The work is without reference to generalisation or with much immediate evidence of a neatly packaged outcome.

The Association of Psychosexual Nursing holds that the Balint style seminar has to be experienced with the pain of unknowing and uncertainty to reap the depth of benefit in practice with the client. I quote from Savage's report a comment from an advanced Balint style group leader: 'It's so much easier to think about the patient and the psychology of the patient than to really stay with the really difficult task of understanding what it feels like to be with the patient now' (Advanced Seminar Leader in: RCN Inst. op cit. 2003).

The initial points would be interesting to consider in the light of Dr Sackin's research report, and against Savage's ethnographic descriptions of participating as a researcher in a Balint seminar for nurses.

Finally, Dr Sackin made a proposition: Does the Balint Society stick rigidly to the pioneers' precepts (psychoanalysts as group leaders) and become another endangered species, or feel the danger of adapting to current 'wants' of the medical profession?

He then suggested a reality, that the 'need' of the doctor and of other health care professionals to make sense of the consultation remains. Although the recent research described by Dr Sackin has yet to be published, he indicated that the essence of the Balint Seminar, re-interpreted in this generation, appears to continue to provide an effective forum for understanding the complexities of face-to-face clinical encounters.

In conversation following, it was mooted that the future of the Society may lie in its openness towards other professional groups who are also struggling to maintain and promote effective ways of working with the practitioner/client encounter. The Association of Psychosexual Nursing has valued the foundation laid by Balint and others, which has allowed small numbers in this generation to find satisfying clinical work within the rigours and expectations of professional practice. Effective training for

practical skill development in the daily face-to-face work with patients /clients needs to be considered by all groups of practitioners and training institutions*. Our common link could be the 'One in a million'.

Alan and I enjoyed a very good evening and we extend our thanks for the openness and welcome that we received from the Society's members and friends.

Post-script

*From our perspective, this form of training for the development of skills in communication with the patient was further developed through Dr. Tom Main and his work with groups of doctors (and nurses) struggling to cope with the psychosexual problems of their patients. Doreen Clifford, Jane Selby and Marjorie Rutter have since pioneered the development of psychosexual awareness for nurses in clinical practice (Wells, D. Ed. 2000, Caring for Sexuality in Health and Illness, Churchill Livingstone). The Association of Psychosexual Nursing is keen to work with other professional organisations in order to enhance psychosexual awareness amongst Health Care Practitioners using the Balint seminar approach and in developing training strategies to that end. It would be good to have contact with you regarding your views, either through our website: www.psychosexualnursing.org.uk, or by email to jean.penman@Bedford-PCT.nhs.uk

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How teaching psychotherapy to medical students can help them to learn about the doctor/patient relationship and the psychosomatic approach to the patient

Peter Shoenberg, consultant psychiatrist and psychotherapist

Address given to the Balint Society on 15 February 2005

Introduction:

Much of the work of a psychotherapist threatens him with too great an emphasis on the mind, just as much of the physician's work threatens him with too great an emphasis on the body. While clinical medical students are struggling to learn how to gain a physical competence to make them safe clinicians, how can we help them acquire the appropriate psychological skills necessary to become sensitive and caring doctors? In order to achieve such a physical mastery in medicine, students often feel they must leave their natural psychological skills behind them. A recent survey of 1593 doctors and 227 medical students in Geneva, which looked at the relative importance of psychiatric topics in undergraduate teaching, found that learning about the doctor patient relationship was considered the most important topic (Georg et al 1999). In British medical schools there has been a new emphasis on helping medical students to develop a professional attitude towards their patients with special emphasis on teaching communication skills so as to help them to become better doctors. There is a need for students to learn to reflect on their experiences with patients and psychotherapy may help with this, as well as giving insights into the doctor/patient relationship and the psychosomatic approach to patients.

Our Department of Psychotherapy is part of a large teaching hospital in central London. Clinical medical students receive one or two formal lectures during their psychiatric attachment about psychodynamic psychotherapy. During this attachment they also have an opportunity to join a short-term weekly discussion group run by one of the senior psychotherapists, to help them think about their emotional experiences of seeing mental illness for the first time,(Brafman, 2003). A small number of students are attached for a short period to our Psychotherapy Unit and the Department of Liaison Consultation Psychiatry. During this placement they get a chance to interview patients prior to their psychotherapy assessment. Some of these have psychosomatic disorders and so give the student the important opportunity to develop insights into psychosomatic conditions.

The University College Hospital Student Psychotherapy Scheme

Students get enormous inspiration from such rewarding and revealing encounters with psychosomatic and other patients referred for psychotherapy. Forty five years ago, Heinz Wolff and Dorothea Ball, two psychotherapists, and Roger Tredgold, a psychiatrist, working in our Department, recognised this and began a scheme for a small number of the first year clinical medical students to see a carefully selected patient for ongoing once-weekly individual psychodynamic psychotherapy. This psychotherapy was supervised weekly by a senior member of our team. The scheme has remained a very popular option for students who want to learn in greater depth about the doctor/patient relationship. Although initiated independently in medical schools in North America, our scheme has been followed and studied by other medical schools in Britain, Canada and Europe, including those in the University of Heidelberg and the University Vaudois in Lausanne.

Often young students do well with patients who are somatisers and also young people presenting with personality disorders. Their gentleness and relative lack of intellectual sophistication may make them better at emotional contact with their patient in such an introduction to psychotherapy, than their counterparts amongst the psychiatric trainees who are often over-loaded with psychiatric theory. Our students participate in the scheme on an entirely voluntary basis, whereas the psychiatric trainees have to do psychotherapy as a pre-requisite for specialisation in psychiatry.

The students who have done this scheme have reported in a recent 10 year retrospective study on how helpful it has been to them in learning to relate to patients (Yakeley et al, 2004).We can see how they have begun to understand the patient's unconscious communications and appreciate the significance of childhood emotional development in the production of adult psychopathology. They are better able to handle discussion of embarrassing topics and feel more confident when handling patients who are aggressive or angry, and also feel less disturbed in their encounters with death and dying. We can see that they have begun to appreciate the links between psyche and soma.

Such an experience gives students the opportunity to learn to listen to a patient and to appreciate the value of continuity of care. Students bring to this project enormous enthusiasm. Although some patients drop out from treatment early on, the majority respond well to this introductory period of, a relatively supportive and exploratory psychotherapy. After

the therapy has ended the patient is given the opportunity to consider having a longer term psychodynamic psychotherapy. In a study of a similar scheme in Heidelberg, (Knauss and Senf, 1983), 30 of 38 patients completed the full course of psychotherapy with the student, and in follow-up interviews 52% considered this opportunity to talk to an independent non-judgemental person to have been the most important experience during their therapy.

Psychodynamic psychotherapy gives the student a unique experience of handling the dependency needs of a patient by his learning about how to recognise and interpret the transference. This provides profound insights into the doctor patient relationship.

At the end of their psychotherapy of their patient, which lasts for one year, students make an evaluation of their work. Recently a student wrote this interesting account of her work with a patient with unexplained medical symptoms:

> "The problems that Jenny was experiencing with her bladder and her bowels were a constant theme during the psychotherapy. In the first few sessions she spoke almost exclusively about them. I thought that they were safe topics we could discuss, as I was a medical student, when other things were too difficult. It was interesting, as, because she knew I was a medical student, I never commented on them as I explained it was not my role, but it was difficult not to get drawn into making some sort of diagnosis.
>
> Her symptoms were of recurrent urinary tract infections and bowel problems associated with pelvic floor and lower back muscle tightening and pain. She also suffered with headaches and lethargy. Jenny was initially reluctant to think that her symptoms were linked to her feelings or emotions... However, by looking at examples of how the mind can affect the body and vice versa, such as the migraine she always got on returning from her parents' house and the strange mood she felt during her periods, she was able to see that her mood did affect her symptoms: for example, she had many fewer urinary tract infections whilst feeling happier, compared with when she was feeling lower.
>
> We explored the significance of her symptoms for Jenny and she remembered that as child she had been very anxious about not making it to the toilet on time, and she feared that she would wet herself in the classroom. As a result, she often spent much of the break sitting on the toilet, making sure she went to the toilet just before the school bell rang, so as to ensure there would be no accidents in the classroom. At home she had been taught that to use the toilet was dirty and in some way wrong, and should never be discussed. This was similar to the way in which emotions were treated at home: we now explored the link between the use of the toilet and her expression of her emotions and wondered if sometimes the toilet was her way to express these feelings. Although she claimed not to understand how this might be, she gained insight into the way she expressed her emotions and eventually could interpret new symptoms in this light. For example, when trying to express her feelings about the ending of the therapy, she developed a cough that interrupted her: she now interpreted this as meaning that she did not want to discuss her feelings about this forthcoming ending which would be so difficult for her.
>
> As we discussed the end of the therapy, she compared it to an antibiotic, by which she meant that she thought it would continue to have an effect after it had ended. This was interesting for me, as it showed her ability to link the medical and emotional side of her complaints to the medical and emotional side of me , the medical student and her psychotherapist. It appeared that I had come to symbolise and indeed replace the antibiotics on which Jenny had been so dependent when we had first begun the psychotherapy".

Such long term experiences for our students who do psychotherapy are clearly deeply rewarding, as well as very helpful to their patients. They also teach the student a psychosomatic approach to illness. Four students from this Scheme have been won International Balint Awards for students in the last 20 years for their descriptions of their psychotherapeutic work with patients.

Balint Groups for First Year Clinical Medical Students

Our scheme, for reasons of clinical safety and the limited numbers of supervisors available, has to be limited to a handful of students, usually about 10-15 each year. This year our Medical School increased its clinical intake to 360 students per year. Ninety students put their names down to be considered for admission to the scheme. We wanted to help those we couldn't place on the Scheme and developed a new project, with the support of the Medical School, based on the ideas of Michael Balint.

We offered 11 of the first year clinical students the chance to join a weekly discussion group which would run for 13 weeks. In this group the students were encouraged to discuss clinical cases that they had found interesting from an emotional point of view during the previous week. Initially I and a Balint trained GP ran two small groups which we merged after one month.

In my first group the students talked about how difficult it felt just to go up to patients who might be asleep, or not in a fit state to speak. One described how frightened she had felt about seeing a very ill patient, who was somehow repellent to her. She said how difficult it felt to get close to him. Another student told us how surprised he had been when a patient with chronic

obstructive airways disease whom he had seen the day before in the Casualty, had waved to him on the ward. This recognition of the student by the patient in his new environment made the student realise the importance of continuity of care. Another student talked about helping a patient she had taken for an x-ray: she had reassured him by explaining the anatomy of his trachea which was about to be x-rayed and about which he knew so little I commented that we seemed to be trying to find something out about the person in the patient. By the fourth group the students had begun to share a lot more feelings with each other. A student talked about seeing an old man with severe peripheral arterial disease. He had been so emaciated that he looked like a bag of bones with his ribs sticking out and his sunken abdomen and his one leg amputated. She had been so shocked when his remaining leg moved that afterwards when talking to her mother about it on the phone she burst into tears. It led to a discussion about the relationship between seeing and feeling, and her own fears aroused by the sight of this man of growing old. We started to talk about the fear of touching patients. Another student described a patient who had come to Casualty who was so badly burned that one could no longer tell the colour of his skin. His hair was charred and his body was covered with ash. The student had felt threatened and frightened when she got ash on her skin from examining him She wanted to cry and felt it would have been good if she had been able to. But others said that students should learn to become objective if they were ever to become truly competent at medicine. The same student now told us how she had taken a history from a cardiac patient. The problem was that he had kept on interrupting her, saying he wanted to talk about the loss of his wife, whilst she tried to persist with her medical questions. He would say, "I'm sorry, but I want to talk about Kate". By his bedside was a picture of Kate, who had had Parkinson's disease and whom he had looked after, during which time he had lost a significant amount of weight. Apparently the patient had refused to have counselling that had been offered to him by the doctors. The group wondered how to help this man, who obviously wanted to talk about his grief. Another student suggested returning to this man, but then what would happen if he began to talk about something the student could not handle? Another student suggested that when somebody talked about a difficult topic the best thing was to try to say nothing and listen. Around this time the other group leader had an accident and so I joined the two groups together. The larger group functioned much better than the small ones.

The group began to consider deeper issues: a student described her first experience of seeing a patient dying in Casualty after a third heart attack. She had been surprised by the peaceful expression on his face, which contrasted with the screams of the relatives in the corridor and the anxiety of the doctors that they might have missed a high serum potassium. We talked about how this first experience of seeing a death had affected the student. She denied that it had been upsetting, yet I noticed that her eyes were filled with tears.

Subsequent groups talked about the histories of patients who did not fit into the hospital system, such as the very demanding homeless drug addict who insisted on the student phoning a homeless persons unit and fetching some orange juice for her, which the student had refused to do, considering it not to be her role. Another student presented an angry, litiginous patient, who was convinced that the ENT surgeons who had put grommets in her ears, had caused her to develop tinnitus. It led to a discussion about why people got angry and why some patients were hypochondriacs. Someone said people got angry often because they were unhappy and perhaps dealing with a broken marriage. Another student described a case of a woman who came to an incontinence clinic complaining that she became incontinent of urine only when she passed a certain building. We all agreed that this might be a psychosomatic case.

A student in a subsequent group talked about a man who had had a coronary by-pass presenting with unstable angina. In the doctor's notes the social history only recorded that he lived with his wife, yet the student had been able to take a long psycho-social history. The patient had told her his wife was becoming increasingly frail. He had wanted to move from their house, which he felt was much too big, but the wife had not wanted to move. On the day of his admission to hospital the weather had been very cold, he had been busy all day, and then he had had a very heavy meal, after which he had to do the washing-up. It was then his angina came on. He had ignored it for one and a half hours before feeling able to call for help. The student commented that the doctor had seemed only to be interested in the medical problems, when it was so clear that this man's social and personal circumstances were so relevant. Another student said it wasn't the case with the Geriatricians, and another student said it wasn't the case with the GPs.

Students talked about patients who were difficult historians and might be devious with them. They wondered if it was because they were only students, after all. In another group, a student described a young patient with ulcerative colitis who said he preferred to talk to her, rather than the doctors, because she was nearer his age. But she had found this closeness in age a challenge. Two students said they preferred to be with younger people, but another student said he preferred older patients with whom he felt safer.

In what seemed like no time at all, we had reached our last group. During the 13 weeks 50 clinical cases had been discussed. A theme that recurred throughout the groups was the problems the students had in order to have sufficient time with the patient, both to listen to the emotional aspects of his story and to obtain a systematic

medical history. The students said how much they had appreciated being given time to talk about their work with patients, to hear other people's views, and that this had given them a fresh outlook and helped them to see things in a new light. They said it had been a revelation to realise that they, as students, could be useful to patients, and that it had stopped them feeling so alone with difficult problems. Next year we plan to expand the scheme and to research it to assess how effective it is with helping the students to learn about their relationship to the patient.

This year our Medical School has funded an extension of this new teaching programme so as to allow up to 40 students to participate in four separate Balint Groups and we are hoping to study the effects of these Balint Groups and the Student Psychotherapy Scheme on students' attitudes to the doctor/patient relationship in a randomised control trial commencing in 2006 (also funded by the Medical School).

Conclusion:

Psychotherapists who work in general medical hospitals have a unique opportunity to enhance the work of their hospital where increasingly the medical services have become more specialised and often separate from psychiatric services. There is now too much emphasis on speed of treatment to reduce the cost of medical care. The links between psyche and soma are precarious, not only in psychosomatic patients, but also between the Departments of Psychiatry and Medicine. Psychotherapy teaching can offer the medical student who is trying to navigate this brave new world a chance to find his own and his patient's emotions behind the diseases he encounters.

The case history in this paper is published with the written consent of the patient.

References

Ball,D H and Wolff,H H ,(1963), An experiment in the teaching of psychotherapy to medical students .Lancet **1**, 214-217.

Brafman, A,(2003),Memorising vs Understanding , Psychoanalytic Psychotherapy **17**, No 2,119-137

Georg,D,de Saussure,C and Guillun ,J ,(1999), Objectives for undergraduate teaching of psychiatry: survey of doctors and students. Medical Education **33**, 639-647.

Knauss, W and Senf,W,(1983) ,Follow-up results of the Student Psychotherapy Project in Heidelberg ,in First Steps in Psychotherapy,(eds H.H.Wolff, W.Knauss and W.Brautigam) ,pp79-90 .Berlin: Springer-Verlag.

Yakeley,J, Shoenberg,P and Heady,A,(2004), Who wants to do Psychiatry? Bulletin of the Royal College of Psychiatrists 28, No 6

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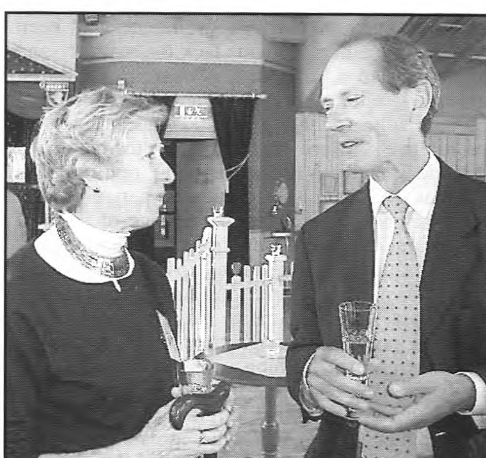

Making Space for the Doctor-Patient Relationship through Balint Training in the First Year of Medical School

The Balint Society Prize Essay 2005

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Introduction

Currently in the United States, Balint group training has been largely confined to the residency level of medical education, particularly in family medicine. While there have been attempts to introduce Balint work in the third year of medical school, as students enter their clinical rotation in family medicine, these attempts have typically been short-lived. Arguments had been made that medical students lack the maturity and experience to do the work of learning in Balint groups, while others see the lack of patient contact during the basic science years as prohibitive. More recently, the curriculum of American medical schools is being revised, with a focus on integrating clinical experiences and basic sciences beginning in year one of medical education. With this new trend, medical faculty are also studying the relationship between success in doctor-patient interactions early on, and later successes or deficiencies in such skills, as students progress through their third and fourth years in clinical training. As an example, one study published this year found that students with paternalistic or negative attitudes toward a small group, faculty-led, first-year course in doctor-patient relationships showed marked deficiencies in establishing patient rapport when tracked through their third year clinical rotations (Murden et al., 2004). This finding suggests that even in the first year we may be able to identify which students will struggle with effective patient interactions, and correspondingly, it seems that it should be in the first year of medical school that we should begin to teach these skills.

In 2004, with nearly fifty percent of the mortality rate in the United States due to behavioral and social factors, the National Academy of Science's Institute of Medicine (IOM) issued a report charging medical schools to increase behavioral science curriculum across all four years of medical education. Such training will help students to better understand the stresses that effect both patient illness and physician performance, particularly in the doctor-patient interaction. The IOM committee identified six domains of minimal competency for medical students, including mind-body interactions, patient behavior, physician role and behavior, and physician-patient interaction. Under the area of physician role and behavior, the report identifies the high priority area of physician understanding of personal values, attitudes, and biases that influence one's patient care. Discussing both conscious and unconscious responses toward patients, the report recognizes that it is essential for medical schools to provide opportunities for students to reflect upon and discuss their emotional reactions to patients, citing Balint training as one method for accomplishing this important task (Institute of Medicine, 2004).

In 1996, the editors of the Journal of the American Medical Association initiated a new journal section for the research and study of the patient-physician relationship. The editors argued that no matter what the advances in the science of medicine, physicians (and medical students) must not loose skills in the art of medicine, grounded in understanding and empathy for the patient's experience (Glass, 1996). Novack et al. (1997) argued that physician self-awareness and effective patient care are intimately related. In citing Balint groups as one method for increasing self-awareness and effective care, the authors suggest that such changes can also lead to increased job and personal satisfaction, as well as enhanced physician well-being. This is indeed what our colleagues at the University of Uppsala, in Sweden, found recently, in studying both Balint-participating and non-Balint trained physicians. Balint physicians reported better management of their workloads, less avoidance of psychosomatic patients, and increased satisfaction with their overall work situation (Kjeldmand et al., 2004).

It seems that we may over-encourage objectivity and personal distance in the training of our medical students. Perhaps we need to teach them the value of understanding their emotional reactions to their patients, either as additional diagnostic information, or as a means of recognizing personal reactions in themselves that may interfere with their effectiveness in patient care (Zinn, 1988). The challenge is to find safe, supportive, and educational ways of learning from our feelings toward our patients, and Balint groups offer a structured means of doing that.

Medical student Balint groups & research:

European and South African Balint leaders and trainers have been using the Balint method of patient-centered training with medical students for over 30 years. Physicians in Italy, Switzerland, Germany, Austria, and South Africa have published numerous articles on the challenges of medical student Balint groups, as well as presented on such topics at both regional and international Balint Congresses (Castiglioni

& Bellini, 1982; Luban-Plozza, 1989; Luban-Plozza, 1995; Schuppel et al., 1998; Sollner et al., 1992; Levenstein, 1980; J. Salinsky, personal email communication, August 11, 2002).

More recently, our colleagues in the United Kingdom have reinitiated medical student Balint groups at the Royal Free and University College School of Medicine in London, the site of the original work with medical students, led by Michael Balint. Groups met weekly, over a three month period, in addition to regular course work and training. The initial success of these groups for first year clinical students (third year of training) has led to a proposal to expand the number of training groups, to provide developing doctors with a means of integrating their own feelings into their patient experiences and clinical skills (H. Suckling, personal email communication with unpublished electronic manuscript, September 14, 2004).

In the US, while Balint groups have become a standard training format in nearly half of all Family Medicine residencies (Johnson et al., 2001), few attempts have been made to bring Balint training into undergraduate medical education. Psychosocial medicine training within the basic science years focuses on developmental theories, learning and cognition, and behavioral aspects of disease. Efforts to offer students a more personal, reflective mode of learning about doctor-patient interactions have usually taken on a combined didactic and small group discussion format, often with a broader theoretical focus than just patient interactions (Davies et al., 1995).

Different medical schools have experimented with ways of incorporating Balint groups into third year clinical training, usually during family medicine clerkships. While students' responses have been mixed, the greatest successes have occurred when the experience has been elective, and of greater duration than just a few weeks. In such training experiences, students often alternate their focus between the preceptor-patient interaction and the preceptor-student relationship. The leader's role also seems to vary between traditional analytical leader and a more didactic facilitator or role model, in leading discussions of specific topics or cases (Margo et al., 2004; Brazeau, et al., 1998).

In order to get the most current assessment of the use of Balint groups with US medical students, I conducted an email survey of the membership of the American Balint Society. I had only seven responses from Balint Society members who currently or recently were running Balint groups with medical students. All groups were with third or fourth year students. Groups met either weekly or every other week, for a total of 3 or 4 weeks during a designated (family medicine) rotation. Groups were both traditional Balint groups and more topic-focused discussion groups with cases interspersed. The greatest deviations from traditional Balint work were in leader behavior: leaders reported taking teaching roles, model participant roles, and more directive roles in soliciting students' reactions. Also noted was an increased focus on the student-preceptor or student-resident interaction, rather than the student-patient experience. There was no reported assessment of these groups, however, students' comments on these experiences ranged from very positive to openly hostile (A. Turner, personal email request and responses on Balint-L list serve, September 7, 2004).

Michael Balint & medical student groups:
Initially, while working with general practitioners, Michael Balint expressed serious concerns about attempting to train medical students through the use of his patient-centered approach. In his writings on training, he identified several reasons why working with medical students was likely to be less effective: 1) students, if required to attend groups, might harbor resentment; 2) faculty evaluations of students might affect student participation; 3) students lacked ongoing patients to motivate them to acquire new skills; and 4) students are generally young, less mature, and lacking in life experiences, unlike many of their patients (Balint 1957).

However, in 1962, following retirement from his work at the Tavistock Clinic, Dr. Balint began working with groups of first year clinical students in the University College Hospital in London. These groups met weekly, during both the junior and senior hospital years. Balint evidently revised his beliefs about training with medical students because he continued to offer these groups at UCH for several years. Like groups with practicing doctors, these sessions allowed the students to safely discuss their frustrations and challenges in working with patients on the ward, and to gain increased awareness of their response options by listening to the discussions of their peers. Balint reports that the medical students in his groups showed an innate ability to put patients at ease, as well as a genuine interest in the emotional life of their patients. Balint also concluded that it was important to start this kind of training early in a student's medical career, so that there would be time enough for the learning and experience necessary to make a lasting shift in the soon-to-be doctor's approach to his/her patients (Balint et al., 1969).

The work of leading Balint groups with medical students at UCH stopped, however, and has only most recently been revived. In reviewing the reasons for the cessation of medical student groups at the hospital, Dr. Tredgold (a contemporary of Balint) identified several 'lessons' which would better ensure the success of medical student groups, if and when they were reinitiated: 1) a system of regular tutorials was needed to support student learning, in combination with group participation; 2) a degree of tolerance around issues of student attendance was needed in recognizing the many pressures and demands on medical students; and 3) the

work of such groups must be supported among the other teachers and administrators within the medical education system, particularly clinical faculty (Tredgold et al., 1972).

A first year medical student Balint group experiment:

The work of bringing Balint training to the initial year of medical school began both as an experiment and as a necessity. First, I was curious and believed in the potential of this training for first year students. Second, after leading Balint groups with family medicine residents for several years, I took a new position and began teaching first year medical students. As a result of this relocation, I had to end my training with residents. This motivated me to ask the question, 'Can first year medical students successfully participate in Balint groups?' and to begin a medical student Balint group experiment. The medical student Balint group was offered as a second term elective in the first year of medical school, to a small group of students participating in the regional first year WWAMI program at the University of Wyoming. There were ten students in the overall class and nine of them elected to enroll in the Balint seminar. The group met twice a month, over the four months of their spring semester, for a total of eight sessions. Group meetings were ninety minutes long. The students had already completed their first semester course in behavioral science in which they examined human development from psychodynamic, learning, cognitive, and social perspectives, as well as behavioral issues in illness and disease, both prevention and treatment. In addition, throughout the first year, the students were enrolled in both Introduction to Clinical Medicine (ICM) and Medical Preceptorship courses, both of which follow a small group tutorial or mentoring model, in which they learn the basic skills of interviewing and examining patients, as well as spend four hours per week seeing patients with a local physician in his/her clinic or hospital setting. With the requirements of ICM for continuity patients, and their weekly time spent with preceptors and their preceptor's patients, students had limited ongoing patient contact throughout the first year. The Balint sessions were held at the end of the class day, on the day following their weekly precepting experience and doctor/patient interaction. As the leader of the Balint group, I had also been their behavioral science professor in the fall semester, and so the students and I were familiar with each other, and used to working in a small group learning format. With no qualified co-leader to work with, the sessions were audio-taped and reviewed in supervision with a certified Balint training colleague at another university.

The most significant and deliberate shift that had to be made in leading the medical student Balint group was in requiring the students to present all cases from a first person perspective, as if the patient were their own, and not under the care of their preceptor. The student's tendency in the first session was to present a case from the perspective of an observer ('my preceptor has a patient who has such and such a problem'). Very quickly we agreed that all cases were to be presented as if they were the student's patient, suspending reality and fantasizing what it would be like to have this patient as your own. After all, there was some underlying reason why the particular patient was brought by the medical student to the group, and giving the student permission to present the case as his/her own patient allowed the student's own transference responses to the patient (and the doctor) to be brought into the group. This is not unlike what we ask the other members of any Balint group to do: to suspend reality and imagine what it would be like to be that patient or that doctor trying to help that patient. In making this deliberate shift, we also give the presenter permission to explore his/her feelings about the patient that had been brought to us, by asking the medical student to imagine that this is indeed his/her own patient and problem. Who knows if the feelings and dilemma presented are exactly what the student's preceptor might be experiencing with this patient? It doesn't really matter. The fact that the student has brought a patient to us tells us that he or she has some unresolved feelings about this patient and their interaction. The stage is then set for the group to do its work, and for the presenter to learn from the group.

In all sessions, students presented patients without hesitation, often coming prepared and quickly offering a case when called for. Interestingly, throughout the group's time together, only patient cases were brought to group; no preceptor-student issues were raised as cases for discussion. Students seemed to grasp (even enjoy) suspending their student role and reacting to the cases as if they were the primary provider or the patient.

A sampling of student cases and theory:

Group #1: After a brief introduction on how the group might operate, I called for a case. Brian spoke up and presented a patient visited yesterday in the nursing home with his preceptor. He described an 87-year-old, widowed female, with Alzheimer's disease, who was very combative and fearful in her interactions with medical staff and visitors. Immediately, one member said that the patient reminded him of his grandfather, and if it were his grandfather, he would like him to be treated such and such way. Other members began to identify with the patient, taking issue with the staff and making assumptions about the physician's style of care. I asked them to consider the dilemma of the provider, perhaps being fearful of getting hurt by the patient's violent behavior, and yet being responsible for the care of the patient. Members struggled with idealized notions of how they would do this, until one member offered that he would want to avoid the patient. Group members then voiced what it

would be like for the patient or the physician to be fearful of each other, and the conflict they would feel in that position. Finally, I asked what kind of physician this patient needed Brian to be. The group returned to the empathic position with the patient, speaking from the first person.

Here, as Balint taught us, the core issue of the student's counter-transference to the patient was explored through the various group members' own elicited transference responses to the patient or the doctor, as they surfaced in the group interaction. The awareness gained from listening to his peers, combined with the group's support and identification with the presenting student's dilemma, helps the student see that he/she is not alone in his/her development and the challenges he/she faces within the particular patient interaction. Once Brian rejoined the group, he expressed his pleasure with seeing the group struggle with the same issues and feelings that he had been struggling with since meeting this patient. He also thanked the group for the suggestions that he identified in listening to their discussions of how they would each interact with this patient.

Group #3. Richard presented a case of a 24-year-old single, female patient, seen in the hospital, following a vehicle roll-over on the highway in which she broke her pelvis and bruised ribs and muscles. Richard explained that before entering the room to interview and examine the patient, he was approached by the nurse who told him to be careful since this woman was a drug or alcohol addict, with a boyfriend in prison, and that she was lying to cover up something. Richard's dilemma was whether to believe the patient or the nurse and what to log in the chart and in his write up for his preceptor (who was not present with him for the patient interview). With that, Richard agreed to push back, and the group joked briefly with him about whether he could keep silent while the group worked.

As Balint first recognized, by creating a group atmosphere in which the members have time to listen, to think, and to feel, even time for a little playfulness in speculation or fantasy, the group leader builds an environment in which the presenting doctor (or student) is free to watch and experience the differing reactions of his peers. He/she can then evaluate those options under the increased awareness of his own automatic reactions and those of his patient. This was the case for Richard. At first the group members worked hard to determine who was telling the truth, the patient or the nurse. Finally there was a voice in the group for the isolation and fear that the patient must be feeling, being in pain, in a strange hospital, and separated from her children. One member suggested that the patient probably wanted to be accepted by this handsome young medical student in the white coat, and not to be judged by him.

As a group develops in trust, safety, and cohesiveness, the threat of disclosing or recognizing individual mistakes, blind-spots, or interfering personal history is decreased, and previously defended intrapersonal conflicts may be allowed into awareness and accepted by the presenting doctor or student. I asked whether the doctor-in-training, too, might want to be accepted by this young female patient, given her voluntary participation in his training. While the group struggled with this suggestion, Richard returned to it later in the group, acknowledging that now he recognized his own needs for acceptance from the patient. He then asked again about his dilemma of who was telling the truth, the nurse or the patient. Two of the members stayed with the patient, and spoke of the doctor being what the patient needed in the present, not worrying about her history prior to this interaction.

Also during the group discussion, on two occasions the group's only female member commented on David's silence and lack of participation by saying that he was so quiet because the patient that Richard was presenting was really David's girlfriend. Although the group laughed, no comment was made by David either time. Perhaps, on some level, David's silence led Brenda to understand that he did have a secret that he was not discussing with the group. This is what Balint identified as a developing crisis in the group: groups may avoid issues when, because of conscious or unconscious feelings, they either protect the presenting doctor from humiliation or embarrassment through compliments or avoided criticism, or they are overly critical and attacking out of their own insecurity and underlying identification with the doctor's (student's) feelings of inadequacy. To confirm this, as the group was ending, David spoke up and told the group that he was 'creeped out' by the physical exam and breast exam that he had to perform on a 20 year-old-female this past week. He was so worried about what she thought of him, imagining that she saw him as trying to play doctor, that he couldn't remember what he was supposed to do, and ran from the room, unable to complete the breast exam.

As leaders, we know that crisis occurs when one member finds it intolerable to accept his/her reaction or behavior toward a patient, or the implication that it may have for him/her about their competency or personal effectiveness as a student or developing physician. When this occurs, members may isolate themselves from the group, often through silence or withdrawal from interaction. In this case, David's silence through the first few sessions of the group was becoming increasingly uncomfortable for the group members. So in a crisis, we have the female member who challenges David's lack of participation, only to have David reveal his mishandled breast exam, which the group isn't sure how to handle, and David has run from, again, as the group is leaving the session.

Balint believed that crisis was necessary within the group, in order for the group to avoid deteriorating into a mutual admiration society, in

which no challenges exist, and everyone is liked, appreciated, and respected for their individual levels of competency. The role and attitude of the leader is crucial in moving the group and the individual member through such incidents of crisis. By modeling in the here-and-now the kind of listening and behavior that we seek to develop in the individual members, and by tolerating the uncertainty of unresolved feelings, the leader teaches by example, making the group safer, again, for the isolated member to join in the interaction.

Group #4: As the group began, Richard, who presented the case last week (followed by David's failed breast exam) said that he had a case, but would wait to see who else would present. After a group silence of less than a minute, Shane told him to go for it. Richard presented a patient with lower back and leg pain. She had recently had an epidural pain treatment done by a specialist. Since the treatment, she had increasing pain and numbness in her leg, decreased reflexes, was not doing well emotionally, and sounded to Richard like she was considering legal action against the specialist who performed the procedure. Richard saw her with his preceptor, her primary care provider. This provider was now recommending that she see a neurologist to determine the cause of her numbness and continuing pain. Richard felt that his preceptor was trying not to get involved. Richard reported that his own dilemma was in regards to his potential conflict of loyalty to the patient or to his colleague, the specialist. The group raised a few questions before excusing Richard. Richard explained that 'Mary' had a thick chart and a complicated history, including ongoing treatment for schizophrenia with her provider, no known surgeries, and a prescription for narcotics, due to the pain, though she seemed to be taking the medication as prescribed. I asked Richard to push back and the group to consider the presenter's dilemmas. The group struggled with imaginings about unknowns in the case: who the other physician might be, whether they knew him, and whether they would get involved or turn their back on their colleague.

Members speculated about what it would be like to be the primary care provider for this patient, attempting to mediate between the patient and the specialist, who performed the botched procedure. 'What would you want if you were Mary?' I asked the group. Almost collectively, the response came back, 'I just want to feel better; I don't want to sue, I just want some hope; just to have someone hold my hand and tell me I'll get better'. Shane offered that it was important for Richard to show his concern, to keep seeing her, even while the other stuff goes on; for her to know that her doctor is still there even if he can't fix it. Mark argued that if he were to pull away from the patient, he would do a disservice to the patient when she needs him the most.

While this was a genuine case that was presented, it is interesting that Richard brought up a patient again, after his presentation last week, and that the issue was about 'screwing up' with a patient, whether you interpret that in terms of making mistakes or sexual issues. As the group went on, it seemed that the issue was not the doctor-patient relationship, but rather the doctor-doctor relationship, and even more personally, the relationship between members of the group. There were many references to 'you guys in here', and not knowing what they would do if it were one of them in this situation with each other. I began to wonder if there were general fears of incompetence being discussed here, or if the timing were such that they were trying to tell me something about David. About his screw up. They seemed clearly able to identify with what the patient needed and wanted, and what the specialist would want to know about the failed procedure; their struggle was with their peer: what do they do or say to their colleague who they feel loyalty to, but is screwing up? Nobody addressed David's admission that he was 'creeped out' by the failed breast exam that he ran from. Was this Richard's and the group's way of bringing back this unresolved business for David? So on one level, we have the real patient with her fears and pains and her provider's dilemma in hanging in there with her or sending her on to another specialist after the first one failed. On a second level, we have every medical student's nightmare that they, too, will screw up, and how would they handle it or want it to be handled if and when that happens. And finally, perhaps we have the very personal level that this is really about one member of the group, that they all believe is over his head, screwing up, perhaps can't cut it in medical school, but that they have this loyalty toward, and feel caught as colleagues, wishing that the 'specialists' (perhaps faculty?) would just figure it out before he ends up hurting somebody.

Balint reminds us that the individual member in crisis may simply be the depository for the other members' own fears of failure; that their splitting with him may in fact be self-splitting, an attempt to disown the 'unacceptable part of myself that I see in you'. With this thought, I felt more comfortable with David, less worried about him, and more interested in getting the group members to re-integrate these unacceptable parts of self as a part of their growth and change. This relates to the idea of creating an atmosphere where the student is free to be him/herself – 'the courage of his (her) own stupidity'. It is about creating an environment in the group where there are no stupid answers, where they can experiment, and this includes David. Balint believed it was the task of the group leader to develop an atmosphere of trust and mutual support in which group members were free to express their own inadequacies in dealing with their patients, even under the scrutiny of the other group members with their reactions to the presenting issues and doctor. My dilemma in leading was how do I model the kind

of attitude and behavior that I hope the students will learn to have with each other and with their patients? How do I approach the session and the students, and demonstrate that attitude of openness and of being a learner, even as the leader? How do I enter the group room (or patient's room) ready to listen and to learn from the group (or patient), thereby making the group safer, again, for the isolated member to join in the interaction?

Group #5. Before the beginning of group, I deliberately sat next to David, at the other end of the room from where I usually sat. The group began by kidding each other about who was going to present a case. I suggested that (as discussed last time) we think about cases that involve ongoing patients. Mark spoke up and presented Lupe, a patient seen with his internist, who had severe coronary artery disease. She was seen for a cardiac stress test, failed it, and needed surgery. But she was a Jehovah's Witness, and as such, wouldn't accept a blood transfusion. She was also currently anemic and unfit for surgery using her own blood. Mark tells us that she could die any day, while waiting to get her blood levels up to those required for surgery. In the meantime, she wouldn't change anything about her lifestyle, particularly her daily house cleaning and chores, even though they gave her chest pain and shortness of breath. The group asked Mark what he is struggling with. 'Her attitude about her health: she is not willing to do what it takes or what the doctor tells her to do!' came his reply. Mark is asked to push back from the interaction, and the group is asked to take the patient as their own. Shane offers that some habits and roles are very hard to change. If it were his mother, it would drive her crazy not to able to clean her own house. And cleaning could be part of her religious beliefs, too. Jason offered that it's hard to ask someone to do nothing; that's taking away her way of life. He could also see her point of view – 'if I'm gonna die, I'm gonna die, but I'm not going to lay in bed all day.' Alan responded that if he were her, in her shoes, he would see it as a trial of his faith – not accepting a transfusion and perhaps God would bless him and help him get over this illness, or he'd be in heaven with Him. Either way he'd done what he was supposed to do.

Then David spoke up for the first time and asked whether we were trying to make her physically better, or just make her feel comfortable about her situation. I asked David to make the first attempt at answering the question himself. David's response revealed that he was listening to the group and to this patient (and perhaps to himself): 'She's coming to me for some reason; obviously she wants to get physically better. So what do I do? Delay her for a while until she can get physically prepared for the surgery and in the meantime extract support for her from her husband, pastor, and family? Or do I just make her feel comfortable – everyone's going to die someday. She's pretty young, though; I would try to do everything that I could.' Brenda then related the story of her own mother's heart surgery and that she died anyway, following surgery, concluding that perhaps it is this patient's faith that is keeping her alive. I noted that up until then, we had been talking about the patient's faith as a hindrance to her getting the care that she needed. To this Alan suggested that perhaps the major problem in this case is that the doctor and the patient really don't understand each other. 'How would it change your feelings about your doctor if you heard him recognize that it is your faith that is sustaining you?' I asked. David again joined in, offering that it might not change the outcome, but that the patient would feel better, and he would have a better relationship with the patient. The group was excited about this shift in the struggle, and Mark re-joined the group, expressing his enthusiasm for all of the insights he had heard in listening to the group. Group members commented positively on the increased energy and freedom of discussion among members, as well as David's new level of participation.

In his writing, Balint reminds us that it is the task of the group to help members become aware of both the automatic responses of the patient and those of the doctor. Together, these two insights allow the presenting doctor (or student) more freedom in responding to the needs of his or her patient, in subsequent interactions. In this group, we see that there are no right or wrong answers, and that the group, despite a life-threatening case, is able to enjoy the insights that arise through the speculation of feelings and ideas. Even the isolated member perceives the group as safe enough to re-enter the discussion, and in doing so, demonstrates his humanity and sameness with his student colleagues. The group seems welcoming of this returning member, as they find a new level of self-acceptance in their own struggles as students and doctors-to-be.

Evaluation and Discussion:

In evaluating this Balint group experience, it would have been nice to have multiple scientific measures of changes in the students compared with non-participating medical students. Such was not case. Members were asked to fill out the university's standardized course evaluation at the end of the course and semester. The students' evaluations were uniformly positive, with high marks given for 'student-teacher interaction' (4.9 out of 5), 'quality of instruction' (4.8 out of 5), and 'quality of course' (4.8 out of 5). The highest mark was given to recommending the course to other medical students (5.0 out of 5). In addition, the students gave written comments as follows:

- 'these situations that we discussed are very real, very common, and very difficult for doctors and students to handle. Practice helps.'
- 'this course offered an excellent opportunity to share experiences with patients and to discuss issues in clinical medicine. It was very beneficial

to interact with peers and gain other points of view on these issues and experiences.'

- 'this was certainly time well spent for me, as well as being more relevant to my career than other courses. I feel that I have become more knowledgeable myself and feel more comfortable dealing with the issues we discussed.'
- 'this class really helped me develop new ways of approaching difficult patient interactions.'

So, can first year medical students successfully participate in Balint groups? At this point I think the answer is a qualified 'yes'. These first year students seemed to struggle with issues very similar to the ones we hear in our resident physician groups, despite their differences in years of training. What isn't present in the first year group are the repeated attempts to medically diagnose or prescribe treatment for the patient, something that often distracts our residents in their Balint groups. Perhaps it is the students' lack of skills in medicine and diagnosis that gives them permission to focus on the interview, the means of interaction with the patient, while they are still young, idealistic, and their own anxieties about becoming good doctors are still very close to awareness.

The answer 'yes' to the question of first year medical students' participation in Balint work must be qualified by the conditions that we have learned are essential for successful outcomes and change on the part of the student/doctor. Both the British Balint Society and the American Balint Society have published papers on the essential characteristics of Balint groups and Balint group leadership (British Balint Society, 1994; Johnson, et. al., 2004). Michael Balint, too, gave us direction in leading student groups through his initial concerns expressed about the readiness of medical students for such work, prior to his experiences at University College Hospital. Taking liberally from the work of these experts, and combining it with this initial experience with first year medical students, I propose the following conditions for successful first year medical student Balint groups:

1. The first year students must have some ongoing interaction with patients on a weekly basis, under the mentorship or tutorship of a local preceptor.

2. The students need to have had some basic course work in behavioral sciences, exposing them to a biopsychosocial model of illness and disease, and some of the underlying theories of human psychological development.

3. Students should be dually enrolled in an ongoing course of introductory clinical medicine where they learn in small groups about the basic skills involved in interviewing and examining patients, under the tutorship of physician faculty.

4. Perhaps such Balint group seminars should be elective or voluntary. After all, that is what we offer community physicians. As an elective experience, the students would still be expected to make a commitment to the entirety of the course or seminar, the length of the academic semester or term. However, as was mentioned earlier, perhaps we also need to make allowances for conflicting schedules, examination periods, and personal illness over the course of the group.

5. And finally, the issue of evaluation. In our initial first year Balint group, this was resolved by making the class Pass/Fail, and passing was based upon regular attendance throughout the term. None of the students had difficulty passing under these course requirements.

The experience of leading a Balint group for first year medical students was both rewarding and enlightening, to see the level of struggle, compassion, insight, and change that these students produced in a learning format that was previously foreign to them. Their eagerness and openness to learn from each other and from the cases that they brought to the group was refreshing and inspiring, as we look at the young women and men who seek to become learned, compassionate doctors for the patients under their care. We hope to continue this experiment in medical student Balint groups at American medical schools, both in our own program, and with others who would like to join us in making space for the doctor-patient relationship and Balint work in the first year of medical education.

References

Balint, M. The Doctor, his Patient, and the Illness. London: Pitman, 1957. Millennium edition: Edinburgh: Churchill Livingston, 2000.

Balint, M, Ball, DH, Hare, ML. (1969). Training medical students in patient-centered medicine. Comprehensive Psychiatry, 10(4):249-258.

Brazeau, CM, Boyd, L, Rovi, S, Tesar, CM. (1998). A one year experience in the use of Balint groups with third year medical students. Families, Systems & Health, 16(4):431-436.)

Castiglioni, R. & Bellini, M. (1982). [The psychological training of medical students using Balint's Method: Analysis of motivations for the group experience.] [Italian] Medicina Psicosomatica 27:411-419.

Council of the British Balint Society, 'Essential and Desirable Characteristics of a Balint Group', adapted from those approved by the Council, March 1994.

Davies, SM, Davies, TC, & Rutledge, CM. (1995). The doctor, the patient: a first-year course for personal and professional growth. Fam Med, 27(7):444-8.

Glass, RM. (1996). The patient-physician relationship: JAMA focuses on the center of medicine. JAMA 275(2):147-148 (editorial).

Institute of Medicine (2004). Improving Medical Education: Enhancing the behavioral and social sciences content of medical school curriculum. Patricia A Cuff and Neal A Vanselow, Editors. National Academy Press, Washington, D.C.

Johnson AH, Brock CD, Hamadeh G, Stock R. (2001). The current status of Balint groups in US family practices residencies: A ten year follow-up study, 1990-2000. Fam Med 33(9):672-677.)

Johnson, AH, Nease, DE, Milberg, LC, Addison, RB. (2004). Essential characteristics of effective Balint group leadership. Fam Med 36(4):253-9.

Kjeldmand, D, Holmstrom, I, Rosenquist, U. (2004). Balint training makes GP's thrive better in their job. Patient Education and Counseling 55(2): 230-5.

Levenstein, S. (1980). An undergraduate Balint group in Cape Town. South African Medical Journal 62(3):89-90.

Luban-Plozza, B. (1989). [A new training method: 20 years of student Balint groups.] [German] Schweizerische Rundschau fur Medizin (Prax.) 78:1192-1196.

Luban-Plozza, B. (1995). Empowerment techniques: from doctor-centered (Balint approach) to patient-centered discussion groups. Patient Education and Counseling 26:257-263.

Margo, K, Goldberg, A, Salloway, K, Thiedke, C. (2004, January). Medical student Balint groups: lessons learned from three programs. Paper presented at the Society of Teachers of Family Medicine Predoctoral Education Conference, New Orleans, LA.

Murden, RA, Way, DP, Hudson, A, Westman, JA. (2004). Professionalism deficiencies in a first-quarter doctor-patient relationship course predict poor clinical performance in medical school. Acad Med 79 (10 Suppl):S46-8.

Novack, DH, Suchman, AL, Clark, W, Epstein, RM, Najberg, E, Kaplan, C, (1997). Calibrating the physician. JAMA 278(6):502-509.

Schuppel, R, Bayer, A, Hrabal, V, Holzer, M, Allert, G, Tiedemann, G, Hochkirchen, B, Stephanos, S, Kachele, H, Zenz, H. (1998). [Interdisciplinary longitudinal curriculum 'Medical psychology, psychotherapy and psychosomatics.' Experiences from the preclinical segment.] [German]. Psychother Psychosom Med Psychol 48(5):187-192.

Sollner, W, Maurer, G, Mark-Stemberger, B, Wesiack, W. (1992). [Characteristics and problems of Balint groups with medical students.] [German] Psychother Psychosom Med Psychol. 42(9-10):302-307.

Tredgold, RF. (1972). Michael Balint and medical students. Psychiatry in Medicine, 3(4):385-388.

Zinn, WM. (1988). Doctors have feelings too. JAMA 259(22):3296-3298.

Balint and the Clash of Cultures

Andrew Elder

(Keynote paper given at the Oxford Balint Weekend in Exeter College on 17 September 2004)

The Society's Oxford conference is an annual opportunity – open to us all – to have a consultation with the Balints' ideas and, most important, to experience being in a Balint group. Having started my consulting career in the 1970s, I am aware how fortunate I was to have had a relatively free professional environment in which to practice, at least for the first twenty years. I needn't tell you that today's world is much more prescriptive. The extent of this change led me to think about the possible effect it may have on Balint work. What is the journey like that we have all just taken – to arrive now in the Balint waiting room – between the daily life back home in our practices (with everything that entails these days) and the life and culture we might expect to find in a Balint group?

The Balints always stressed that new ways of working introduced to doctors through the group work had to be *sufficiently compatible* with their existing professional approach not to be rejected as a 'foreign body'. There must be enough difference, they thought, but not too much. This tension has most often been thought of in terms of the ideas introduced and language used in the group. However, I found myself thinking about how hard it might be for doctors nowadays to move between the priorities and attitudes that may be prevalent in their Primary Care Trusts (PCTs) and practices, and those found in a Balint group, particularly if they were attending a group on a regular basis. If doctors change as a result of being in a Balint group how possible would it be to sustain and develop such a change whilst continuing to practice in the present environment? Is the gap too great? Or, does the gap force different expectations of what a Balint group might be able to achieve? If there is a much greater 'clash of cultures' nowadays than there used to be, then the idea of a Balint group is more likely than ever to be experienced as a 'foreign body'. Part of the attraction (and drawback) of a weekend meeting is that we can meet, work and experience some of this but without having to confront the problems that would become apparent if we were working in a group on a longer-term basis.

Mainstream

Of course, what I am characterising as the majority or mainstream GP culture has, within it, many different and contradictory strands. Some are helpful, others less so. Amongst the latter, there is the familiar over-emphasis on apparently objective knowledge; not new, but what is new is a contract (voted for by general practitioners) in which clinical parameters are set in Whitehall, 'quality' points attract increasing financial reward, personal registration is at an end, and many practices now run appointment systems encouraged by PCTs that undermine continuity. The sum of this is a hefty push back down the always slippery slope towards a more impersonal, disease-centred, and soon-to-be mini-specialist system at primary care level. Despite all this, GPs top the polls of trust in professionals, scoring 92% in a recent *Guardian* survey. And, as Michael Courtenay pointed out in his keynote address of 2000 'Balint and Emotional Intelligence', this contractual straitjacket runs contrary to recent developments at a research level, where the neuroscientists are busy joining us up again by delineating more clearly some of the connections between body, brain, emotions and mind.[1] This is the brave new world of splendid new '-ologies' – like psychoneuroimmunobiology! For an excellent overview of this current research I would recommend the bestseller: *Why Love Matters: how affection shapes a Baby's Brain*[2] by Sue Gerhardt. Perhaps one day this work will drive a re-integration of our overly divided clinical disciplines. It seems a long way off!

In general practice we have always been dogged by the inherent difficulty of our job definition. As a profession we've never accepted the fundamental nature of the conceptual change that arrived with the Balints. How can our leaders defend our territory if we can't do so ourselves? Our new contract awards points (and rather a small number!) for something it calls 'holistic care' defined as an all-round addition of scores for other specialities. Such a concept is likely to be anathema to a Balint doctor, as you would have thought it also would be to most general practitioners. This kind of nonsense could never have been accepted if, collectively, we had been able to absorb the radical nature of the change that comes with moving to an inter-personal view of our professional role. Such a change, however, cannot be sustained without the corresponding change occurring in the wider medical culture and this hasn't even begun. In 1993 a group of us wrote, 'It is not simply that our work is made up of little bits of everything (gynaecology, cardiology, etc). Rather, its essence lies in being an accessible generalist and in resisting such sets of definitions.'[3]

Balint groups

Now let me say a word or two about Balint

groups. If the world outside seems an over-simplified place – too narrowly evidence-based, too concerned with incentives to be 'NICE', then a good way of describing a Balint group is a place where apparent contradictions can be tolerated. Where a space for experiencing, feeling, and re-thinking is opened up, and then has to be tolerated – held open – often having to resist an inherent tendency for spurious agreement and homogenous thinking to re-assert itself. In a Balint group, confidence can slowly be established in the value and legitimacy of feelings as an integral part of professional work. Unusual in clinical medicine, Balint work places emphasis on the value of the unknown. Not as a thing in itself, but in what may be discovered *between, or by, two people (or more if in a group)* when approaching each other with an attitude of openness. In a group, we can make more sense of what we barely notice in our consulting rooms; and increase our capacity to observe the rhythms of body and mind, medicine and metaphor; and learn to distinguish better between self and other, doctor and patient; and with that, comes a recognition of how all reported events are dependent on the person of the observer. I can still recall the moment in my first Balint group, about one or two years in, when I suddenly realised that one of the group members (and still a good friend) was forever presenting the 'same' patient. And if he was, then so was I.

Balint work has its main arena in an area of the mind that used to be referred to as pre-conscious, a kind of anteroom to our fully conscious lives: a *place between* the unknown and the known; the unfamiliar and familiar. It is from this territory that surprising realisations arise; consultations which take an unexpected turn, and moments in groups when a doctor begins to see his or her work in a new light. Such moments are often energising when they occur, but can be hard won. Enid Balint describes this in her essay of 1975 'The Psychoanalyst and Medicine', '...my aim is to show that the analyst's main contribution to medicine is in establishing the naturalness of man himself. This includes particularly those aspects of man which may seem the most irrational and unacceptable, but in which some not wholly defended part of the mind can just be perceived by a trained observer; a part of the mind through which, once it is perceived, each man's uniqueness can show itself. I speak deliberately here of the mind, not the unconscious.'[4]

Balint groups are often thought to be groups for training professionals in the use of their counter-transference responses to patients. Although encouraging a greater awareness of the doctor's feelings during the course of professional work is important it is not the whole story. Balint groups are not primarily about teaching doctors psychotherapeutic skills. The Balints were suspicious of the tendency 'to teach' from whatever source it arose, believing, I think, that it was often likely to be short-circuiting the emergence of something more valuable. This would apply as much to group interpretations, explaining to a doctor why he might be reacting in a certain way, or issuing a prescription. These tendencies are unavoidable, but should be scrutinised, not thought to be the aim of the enterprise.

John Salinsky told us in his Balint Memorial Lecture of 2001 that 'the Romans (psychoanalysts) have gone and are not likely to return'.[5] It does seem to be true for the moment of psychoanalysts themselves, but I'm glad to say, judging from this week-end, it seems far from true of psychotherapists and other psychodynamically-minded professionals who have an interest in our work. The fuller perspective gained through Balint work arose out of the coming together of different professions: both were concerned with human relationships but came from either side of the historical separation of body and mind. How else are we to remain innovative and not become formulaic in our leadership of groups unless we work together, thinking beyond the limitations of our habitual professional viewpoints?

In conclusion, there are many different and useful aims for working in a Balint group. But it may be that long-term change becomes more difficult if the general culture is less hospitable. If the gradient becomes too steep, the role of the practice as a stepping-stone between the two becomes all the more important, providing a place from which doctors might choose to go into a group but also somewhere sympathetic enough to return to and develop their ideas. A halfway house – but how permeable is the practice membrane? Does it successfully keep unhelpful influences at bay, and maintain and develop a reflective culture within?

It does seem to me that Balint groups and the approach to medicine they represent have always been counter-culture. It is easy to argue that this is even more the case now than it was, say, thirty years ago. But even in those earlier days, when judged from the mainstream, there was probably no more than a marginal acceptance of the importance of emotions in the practice of medicine – even the patient's, let alone the doctor's – and the inter-relation between the two. If the approach that Balint initiated is fully taken to heart it changes everything. Thus until (or, if ever) the main culture changes, and with it the medical culture, we are destined to remain a small but persistent minority.

Iain McWhinney stated the problem very clearly towards the end of his paper to the 11th International Balint Congress in 1998: 'The Physician as Healer: the Legacy of Michael Balint': 'The implications of Balint's ideas for medical education have not yet been addressed. We speak of adding skills and competencies, but not of teaching a new way of being a physician. The difference between these two ideas is fundamental: one is additive, the other transformative; one assumes that the status quo is

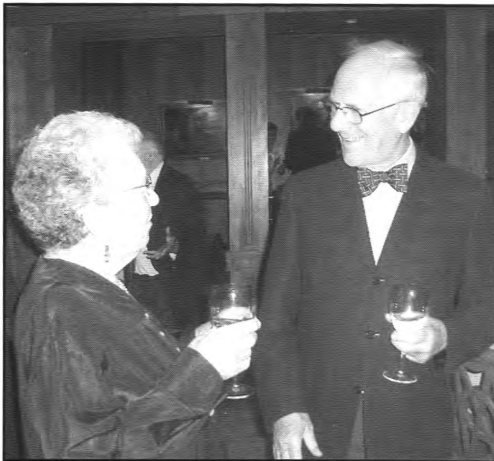
adequate but incomplete, the other that the status quo is fundamentally flawed; one sees the solution in terms of additional tasks, the other in terms of a transformation that will affect everything the physician does.'[6]

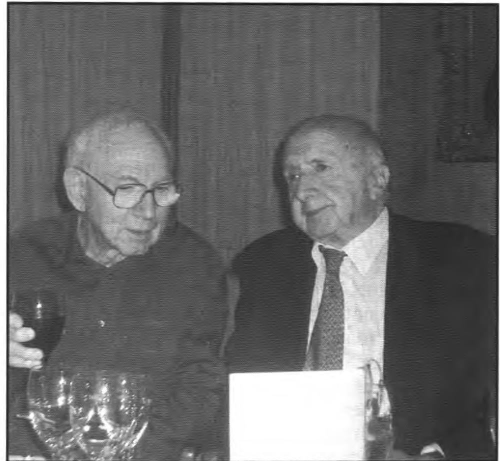
I started by saying that Oxford is our opportunity for an annual consultation with the experience of being in a Balint group. After a consultation, patients often say 'You know, doctor, I'm not sure why but I always feel better after seeing you'. It's the same with Balint. At a professional level we end up more connected to ourselves.

References

1. Courtenay M (2001) 'Balint and Emotional Intelligence'. *Journal of the Balint Society* 29:31-33.
2. Gerhardt Sue (2004) *Why love matters – how affection shapes a baby's brain.* Brunner-Routledge: Hove and New York.
3. Balint E, Courtenay M, Elder E, Hull S, and Julian P (1993) *The Doctor, the Patient and the Group.* Routledge, London and New York.
4. Balint E (1993) The Psychoanalyst and Medicine: 1975 Freud Memorial Lecture. In *Before I was I* (Ed Mitchell J and Parsons M) Free Association Press: London.
5. Salinsky J. (2001) 14th Michael Balint Memorial Lecture: 'Balint groups and psychoanalysis: what have the Romans done for us?' *Journal of the Balint Society* 29:24-30.
6. McWhinney I (1999) 'The Physician as Healer: the Legacy of Michael Balint' in *Proceedings of the 11th International Balint Congress 1998* (Salinsky J, ed.) Limited Edition Press, Southport.

The Annual Dinner 2005





Book Review

Beyond Depression: a new approach to understanding and management **by Christopher Dowrick,** Oxford University Press 2004. 217 pp. Paperback. £19.95

Christopher Dowrick is Professor of Primary Care at Liverpool and a working GP. He has written a brilliant and highly critical account of the clinical concept of depression together with some helpful thoughts about how we can best be of use to our unhappy patients. His starting point is Robert Burton's Anatomy of Melancholia which provides a long winded but comprehensive and still relevant account of the condition we call 'depression'. Having introduced us to this great work with some tempting quotations, the Professor then provides a brief map of the journey he is about to take us on. He begins (in chapter two) by putting the case for our present day disease-centred approach to depression, including the definitions, the epidemiology and the treatment. Then, in chapter three, he dons wig and gown, becomes counsel for the prosecution and starts to undermine everything we have been taught. We learn that psychiatrists themselves can't agree on the definition of depression. The symptoms seem to overlap confusingly not only with those of other kinds of mental suffering such as anxiety but also of back pain, heart disease, unexplained physical symptoms and just plain old social problems. A cool critical eye is cast on the research evidence for depression as a biological disorder. All right, maybe it's not so simple, but antidepressants are very effective aren't they? Well maybe not. There's a big placebo effect and, for some reason, it's increasing. Another intriguing research finding is that patients whose 'depression' is not detected by their hapless GP actually fare better than those whom he diagnoses and treats with tablets.

In chapter four the prosecutor really gets going. He puts it to us that there are all sorts of vested interests involved in persuading us that depression is a disease. The drug firms have joyfully seized on it as a marketing opportunity. Psychiatrists win more respect from physicians by using a biochemical approach and talking like proper doctors. Academics retain their jobs by writing lots of papers. Even we GPs feel better if we can solve those complicated life problems we don't really want to hear about by the prescription of a single daily tablet.

But the downside of all this dubious medicalisation of human unhappiness has to be measured in side effects, life long medication and sheer ineffectiveness. When I look at my patients who are taking an antidepressant, I find that most of them have been on it for years and they are still miserable. There must be a better way and Christopher has some inspiring suggestions. In chapter five ('Broadening the Mind') he takes us on a tour of anthropological, linguistic, philosophical and literary contributions to the investigation of sadness and depression. We learn about the medieval sin (or 'synne') of accidie and the poetic state of ennui both of which seem to describe a despondent feeling that life is pointless and not worth getting out of bed for. Then there's the Buddhist concept of Dukkha, which reminds us that to live is to suffer and that any happiness we achieve will, like life itself, be transient.

So what is to be done to help our unhappy patients if their misery can not be charmed away with the magic of prozac or even venlafaxine? In his final chapters, with illustrations from literature and from his own patients, Christopher reminds us that to cope with life we have to have a sense of ourselves as real and enduring. We need to engage with life in the community so that we have a network of people whose friendship supports and renews us. We need to feel that our life has some meaning if it is to have any sweetness. Christopher warns against too much introspection but warmly recommends good conversation with your doctor. He reminds us how important it is to listen and share the feelings. But he also recommends a more active approach, with suggestions about getting more involved with life (like taking up a hobby, doing voluntary work or falling in love). And patients also need our help to tell a better story about themselves. I was a little surprised and hurt that there is no mention of the Balint approach which has been facilitating good doctor patient conversations for 50 years. When I emailed the author and pointed this out he replied that he wanted to steer clear of anything based on psychoanalysis! Perhaps we should invite him to an Oxford weekend. He might conquer his fear of Freud and find that we have much in common. Anyway, I seriously recommend this book. It is controversial and provocative but also full of old fashioned wisdom; and if you like your wisdom evidence based, there are plenty of references. I think it deserves to become a classic.

John Salinsky

Obituaries

Mark Sundle

Mark Sundle, who died of a stroke in September 2004, served as GP for over thirty years in Edgware, NW London. He was a gentle, benign and amusing Irishman whose only known vice was golf. Early in his career he joined a seminar at the Tavistock Institute and he remained a Balint doctor to the core, bringing balance and a sensitive understanding to his patients, who held him in deep affection, and to his colleagues who trusted him absolutely. He had a wide range of professional interests. This led him onto the editorial board of Prescribers' Journal and to working for many years in dermatology clinics – work that he continued after he retired from general practice.

He was interested in teaching and learning and for many years took registrars in training into his practice. Such was the feeling of loyalty and affection that he generated that, when he retired from medical practice, fourteen of his ex-registrars turned up to pay him tribute. He was open-minded and willing to try anything, so on being invited to help in running groups at the newly formed local GP training scheme he joined in with his usual enthusiasm. This was an experimental time, for up to then Balint Groups had been largely run for doctors established in their careers and ran with the same membership for two years or more. Most were led by psychoanalysts. Trainee groups were virtually unknown and Mark joined the experiment to create the new model. Almost nobody had tried to run a Balint group with a membership that constantly varied, forever interrupted by bleeps, with members who knew nothing about such groups, but were expected to join in regardless. Mark's empathic enthusiasm was invaluable, and he provided warm, rock-steady guidance as we learned how the groups worked and how to help members feel comfortable sharing their problem cases and discomforts. The doctors who came to these early sessions varied from young beginners to middle-aged physicians, local graduates and refugees from Uganda and elsewhere. At one time the groups included social work students too. It was all an exciting experience and although at times chaos may have threatened, nothing ever troubled Mark. Away from medicine, he contributed his growing professional groups' skill and urbane calm to a (hysterical) counselling course for rabbis. Nothing fazed him.

One of his registrars told me that she doesn't remember tutorials so much as sharing meals and talking about work, being gently tutored by example and kindly criticism almost always informally and at unexpected times. She felt like a member of the family. So did so many of his patients who became close personal friends as well. And he never seemed to forget anyone – who they were related to, where they lived and why he found them so interesting. Marky seemed to share his warmth and support with everyone who came his way.

Oliver Samuel

Max Mayer

Max was born in Bonn on 30.8.1913 and died in London on 22.1.05, aged 91.

He had to leave Germany when the Nazis came to power in 1933, moving to Rome, and then to Bari where he qualified as a doctor a few years later. The creation of the Rome-Berlin Axis drove him to leave Italy and he went to India. From there he went to Dublin to take an Irish medical degree in 1938 and then returned to India. At the end of the war he came to Britain. This circuitous route was dictated by his being a German national, though with family connections in Italy. India may have been a logical move to establish his anti-Nazi credentials and pro-British stance.

I met Max in 1960 as a member of my first Balint group in its second phase. The custom then was that after three years in a group, it was split up and its members were re-assigned to another group which had also been partially re-assigned. In this way I found myself with only one doctor with whom I had previously worked, getting to know six new colleagues and a new leader. (In passing, I have today no idea why this Paul Jones type changing of partners was instituted, though I suspect it was to prevent groups going on too long). I found it easy to relate to Max although at first sight I might have found his urbanity to represent the classic 'superior' doctor stereotype. It took little time to discover this was not the case, but rather that he was a man who had found peace within himself after a very threatening period of his life had been weathered successfully. One effect of the shuffling of group members was to produce temporary regression in group members (I speak for myself!), in that the incidence of 'pregnant nun' cases appeared to be high. But Max seemed singularly free of this tendency and presented workmanlike cases on a regular basis, and his urbane facade did not prevent me from feeling very warm towards him. Unfortunately, in the event, our first working association lasted little more than a year as the second phase of the group came to an end rather prematurely due to the departure of the leader. Some years later we worked together on a Balint project and I remember him then being immensely proud of his young wife and the twins she had borne him. His address to the A.G.M. in 1973 was incorporated in the second volume of the Journal of the Balint Society for that year. This paper, entitled 'Habits', perfectly encapsulates his wit, his spirit of philosophical enquiry and his independent stance. Thereafter I continued to meet Max in a variety of professional contexts related to Balint work, and my abiding memory of him was that of a warm human being and a doctor dedicated to his patients' wellbeing. He is survived by his wife, Yvonne, and their three children. Also, his son by his first marriage is currently a professor of thoracic medicine in the U.S.A.

Mike Courtenay

Secretary's Report 2004-2005

Oxford
The Oxford weekend was held at Exeter College from September 17-19. Attendance was 40 with a good mix of GPs, newcomers, psychotherapists and two medical students.

There were two visitors from Iceland and an envoy from Manila in the Philippines. People come to the weekend to refresh their GP practice, to learn leadership skills and to view a model which they may take back home. The conference began with a keynote address 'The Consultation, The Heart of General Practice', given by our vice president Dr Andrew Elder. Over the three days there were four small group sessions. On Saturday afternoon we reintroduced a fish bowl group session, as we had not been sent many papers for a small paper session. This was led by Dr Heather Suckling and myself and was considered at the plenary to be a very successful session, to be repeated next year at the same time in the weekend. The conference sessions concluded with the AGM of the Society before lunch on Sunday.

Lecture Series
There were five lecture/seminars at the RCGP, starting on October 19th with Dr Sonya Baksi, a retired Community Paediatrician, who had been in Michael Balint's earliest student groups at UCH. She felt that all the group participants she could remember had gone on to interesting lives, perhaps due to self-selection or perhaps something to do with the groups. Her most vivid memory of them seemed to be as a place where medical students spoke about sexual matters more openly, so that they could take this attitude helpfully back to their patients. On November 23rd Dr Tessa Dresser led a discussion on the possibilities and realities of GP appraisal, using her experience in Brent as a basis for thought. It seemed to indicate high hopes which might often not be fulfilled. In the New Year on February 15th Dr Peter Schoenberg talked about the new student Balint groups at UCH and how they might be the basis for a psychosomatic approach for medical students to their future work. The Society is tremendously excited by this ongoing medical student group work and is trying to develop it elsewhere, though it takes very committed leaders. March 15th brought Dr Rob Hale, a senior psychotherapist from the Tavistock Clinic to talk about the Sick Doctors Scheme. This scheme, which has been established for many years, provides ongoing psychological and psychiatric help to doctors finding such help difficult to access through the normal NHS channels. We are very keen to maintain our links with the Tavistock Clinic, both to try to support their Balint work and also to enrich the life of the Society. The final lecture was the 16th Michael Balint Memorial Lecture, held in the Long Room of the RCGP and preceded by a short reception for about 50 people. We use this to bring in an audience outside the Society to try to publicise our work and programme. Dr Paul Sackin, a former president of the Society and a GP in Cambridgeshire, entitled his talk 'One in a Million'. He described the history of Balint work through his own life from medical student groups at the UCH in the late 1960s to the present day, as forming an undercurrent to his professional development but not the dominant feature.

Chester
The fifth Chester weekend was on May 14th and 15th, shortened to include only one overnight stay, but with the same number (five) small group sessions. It was led by Dr Doris Blass and me, the organiser Dr Caroline Palmer unfortunately having last minute family concerns which meant she could only be there to welcome us but not participate in the weekend. There were ten of us in all, including six practising GPs (one of whom was also a psychotherapist) and two counsellors from the University of Manchester Student Counselling Service. We worked from 9.45 on Saturday morning until 2.30pm on Sunday with one break on Saturday afternoon. Perhaps it was partly this shortening of the weekend which made it seem very intense, and certainly for the leaders, very hard work. It seemed slightly less socially cohesive than in past years, and maybe this was because there was less time to relax together than in previous years. Next year we may move to a new venue, which would allow more people to attend, and for us to revert to a full three-day weekend event.

Group Leaders Workshop
This met three times this year in seminar rooms at the Tavistock Clinic. Attendance is made up of Londoners who run or who have run groups, some staff from the Clinic involved in their Balint group, and group leaders travelling from outside London, usually to present their group work. The first meeting on October 12th was one such, when Amanda Daykin and Dr Richard Pannett came down from Norwich. To demonstrate their leadership they actually ran the session as a Balint group, another way of trying to learn leadership from each other. The second meeting on 24th February was a similar meeting when we were unable to find leaders who wanted to demonstrate their group. Instead, we had a group leaders' workshop group along the lines of the German Balint Society's training model. At the final meeting on 14th June Dr Doris Blass and I discussed the Chester weekend with a combination of audio tape, audio transcript and session reports. We hope the Workshop will continue to flourish and already have a presenter, Dr John Salinsky, for the next meeting on October 20th.

Annual Dinner

This took place on June 28th in the new Garden Room at the RSM with 21 guests, addressed by Mr Alan Naftalin, Consultant Obstetrician and Gynaecologist at Newham University Hospital in East London, and husband of our treasurer, Dr Doris Blass. He has made many efforts to introduce Balint work to his hospital community, which have fallen on not altogether fertile soil. He made us feel that the consultation must be valued and with it the work of Michael Balint in a hospital world even more driven by outcomes and figures than we are in General Practice.

Writing now in July, I am looking forward to the 14th International Balint Congress in Stockholm from 24th to 27th August, and to our own Oxford weekend, which takes place from September 16th to 18th with the theme: 'Back to the Consultation'.

David Watt

Balint in Russia: current news

by Vladimir Vinokur PhD, St Petersburg, Russia
Professor, Department of medical psychology, Medical Academy, St Petersburg, President, St Petersburg Balint Society, Russia

Since 1995, when the St Petersburg Balint Society was established and registered with the regional administration, the Society is gradually spreading activities into other parts of the country. As there is no national Balint Society and no other relevant regional societies in Russia, we feel ourselves to be responsible for the promotion of this work to other parts of the country. In 2000, we led Balint groups for social professionals within the European TACIS programme 'Work-related stress in Russia and its prevention'.

In 1995, Balint groups were introduced into the postgraduate educational and training curriculum for physicians and medical psychologists in the St Petersburg Medical Academy (first in the Department of General Practice, later in the Departments of Medical Psychology, Psychotherapy, Paediatric Neurology and Family Medicine). The relevant special courses were developed in 2001 for psychologists in Law and Police Academy, and in 2002 for school psychologists and teachers in their postgraduate training. Now the Institute of Practical Psychology in St Petersburg, affiliated to our Society, provides short courses on Balint group development and promotion for physicians and medical psychologists from different regions of the country and so brings a new energy into this process.

We are very satisfied that a number of new groups were created in St Petersburg and other regions with our support and under the supervision of the Society, so we keep effective cooperation. We are convinced that the core aim to be realized in this process is to keep their activity in conformity with the guidelines of the International Balint Federation, especially with regard to the appropriate styles of leadership in Balint groups and to their basic psychoanalytical ground. So we have started short but repeated training courses for leaders in different regions to help them to obtain relevant knowledge and effective skills in running the group and to prevent people from inappropriate leadership. These training courses are provided twice a year and are supported by the Institute of Practical Psychology in St Petersburg. This is their part of the job – to collect the people and to supply all the staff who are necessary for this work. To some degree, our leadership seminars look similar to the relevant system in other countries; the peculiarity is the essentially bigger volume of theory on professional burnout, physician-patient communication and Balint work, presented there. It is very helpful and encouraging that annually, we provide several meetings with our colleagues from the Russian Group–Psychoanalytical Association where we share our ideas and experiences on the Balint group foundation, content and process.

The evaluation of the effectiveness of Balint groups is gradually becoming the subject of our scientific researches. The paper on this subject in Balint work in different social professions was published in the Proceedings of 13th International Balint Congress (Berlin, 2003). The new research related to this topic was successfully conducted last year and it has been awarded the PhD degree from Psychological Depart-ment of St Petersburg State University. Our other current studies are aimed at the investigation of psychological grounds and symptoms of burnout in health care professionals, and at different aspects of the doctor–patient relationship in psychosomatic clinics, because from the very beginning the St Petersburg Society was closely related to the Department of Psychosomatic Medicine and still maintains cooperation with it. We are aware that these studies should be in accordance with evidence-based scientific principles. That means the necessity to find out the variables which reflect the effectiveness of Balint groups appropriately, and define the tools (inventories and scales) to measure them.

Now we are planning new steps in these researches and we believe they will be fruitful in the scientific and practical dimensions.

Contact: vavin@peterlink.ru

The International Balint Federation

Heather Suckling

Membership:
The British Balint Society is one of 16 national Balint Societies that fulfil the criteria of membership of the International Balint Federation and we hope that this number will soon increase to include all the societies who participate in international Balint events.
All members of the British Balint Society are welcome to attend the international meetings. These are advertised on the website "http://www.balintinternational.com" www.balintinternational.com. and most of them are conducted in English.

Events 2004-2005:
Dubrovnik June 2004.
The Croatian Balint Society invited the Council of the International Balint Federation to join them at their annual School of Balint, in Dubrovnik from 7th - 12th June 2004. The theme was ìPatient-centred Medicineî and the language used throughout was English. Each morning there were short papers on this theme, followed by a group. Most evenings were spent on social activities, concerts and delicious meals in seafood restaurants. There was a fascinating guided tour of Lokrum Island where we discovered much about the local flora.

The Council meeting was held on 12th June at which seven countries were represented. We were pleased to welcome the Balint Society of Serbia and Montenegro as a member of the IBF. At the same meeting we agreed Criteria for Membership as we wish to establish the Federation as a respected International organisation. The German delegation proposed, and the meeting agreed, that the IBF should ask the European Union to include Balint work in the compulsory training for General Practice.

Belgrade November 2004
The newly established Balint Society of Serbia and Montenegro invited the President and Secretary of the IBF to speak and lead groups at their inaugural meeting in November 2004. We were impressed both by the professional work of their society and their generous hospitality.

Campanet, Mallorca January 2005:
The German Balint Society invited the Council to hold its next meeting during their School for Balint Leaders in Mallorca. The programme consisted of papers that were presented in English and groups, some of which were specifically for Leadership Training. were held in both English and German. As usual at Balint meetings there were delightful outings and meals in a wonderful setting. Some Spanish colleagues were present and indicated that they wish to become part of the IBF.

The Council meeting that was held on 22nd January 2005 approved a formal Election Procedure for the Officers of the IBF, agreed on how the funds of the IBF funds could be used and reminded members of the IBF website "http://www.balintinternational.com" www.balintinternational.com. Anyone wishing to add items to the website should contact Heide Otten "mailto:heideotten@gmx.de" heideotten@gmx.de

International Balint Congress, Stockholm 24th-27th August 2005:
At the time of writing the members of the IBF are looking forward to this congress ìBalint work in a time of change and Crisis in the Healthcare Systemî which promises to be an excellent event with high quality presentations, lively groups and enjoyable social events. Details can be found on the congress website "http://www.balint.se" www.balint.se

Miercurea Ciuc, Transylvania, Romania, 22nd-25th September 2005:
The Romanian Balint Society is organising an international meeting on The Balintian Approach to Psychosomatic Disorders' to which you are warmly invited. If you are interested please contact Albert Veress
"mailto:alveress@topnet.ro" alveress@topnet.ro

Future events:
Muradif Kulenovic School of Balint, Dubrovnik, Croatia 6th-11th June 2006:
The Croatian Balint Society invites you to the annual School of Balint 2006, the theme will be 'Doctor-patient relationships and the Ageing Process'. For further information please contact Sanja Balzekovic-Milakovic
"mailto:sanja10@net.hr" sanja10@net.hr

International Balint Congress 2007:
The Council has agreed on a venue for 2007 International Congress, it will be in Lisbon, Portugal, but the date is yet to be confirmed.

Please see the website for a full list of activities.

Heather Suckling is General Secretary of the International Balint Federation.

The Balint Society Prize Essay, 2006

The Council of the Balint Society will award a prize of £500 for the best essay on the Balint group and the doctor-patient relationship.

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2006** and sent to:

Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

The Balint Society
(Founded 1969)
Council 2005/2006

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International Balint Award for Students

Medical students are invited to submit a paper based on their personal experience of relationships with patients and include critical reflection. Prizes totalling SFR 5,000 will be awarded to the best essays. Papers in English, French, Italian and German will be accepted.

The criteria by which the reports will be judged are as follows:

Exposition: the presentation of a truly personal experience of a student-patient relationship.

Reflection: a description of how the student actually experienced the relationship either individually or as part of a medical team. This could reflect multiple relations between students and staff of various specialties and the working routine within different institutions.

Action: the student's perception of the demands he or she felt exposed to and an illustration of how he or she responded.

Progression: a discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Submissions of up to 15 pages should be sent by e-mail as a word attachment to:

Geschäftsstelle der Stiftung Ascona (email: stiftung-ascona@web.de)

Or : Geschäftsstelle der Deutschen Balintgesellschaft (e-mail: Geschaeftsstelle@balint gesellschaft.de)

They should be received before 30 April 2006

You will find more information on the International Website: www.balintinternational.com

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Guidance for Contributors

All manuscripts for publication in the Journal should be submitted to the Editor, Dr John Salinsky by email: *JVSalinsky@aol.com* as a word file.

We welcome research papers, personal reflections, case studies, book reviews and reports of Balint events and ongoing groups.

References

References may be in the Harvard or Vancouver style. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

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